

12859

## CERTIFICATE OF DEATH

12794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHILLUM</b> c. LENGTH OF STAY IN 1b <b>10 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1408 LEGATION ROAD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHILLUM</b> d. STREET ADDRESS <b>1408 LEGATION ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THEODORE WILLIAM ALEXANDER</b>		4. DATE OF DEATH Month Day Year <b>NOV. 25 19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/86</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill man (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milling &amp; Lumber Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN S. ALEXANDER</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA HILLARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-03-6234</b>	
17. INFORMANT <b>Mrs Leo P. Darr, 1408 Legation Rd., Chillum, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Thrombotic Embolism of Heart</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart disease</b> DUE TO <b>Arterio-sclerotic Heart disease</b> (c) <b>Arterio-sclerotic Heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs</b> <b>7 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/19</b> , 19 <b>53</b> , to <b>11/25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/25</b> , 19 <b>58</b> , and that death occurred at <b>6:05 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis X. Richardson</b>		ADDRESS (Street, city or town, state) <b>7717 Alaska Ave NW, WASH. D.C.</b>	
DATE SIGNED <b>11/25/58</b>			
PHYSICIAN'S NAME (Type) <b>FRANCIS X. RICHARDSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/29/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2833

18701

<p>NAME OF DECEASED                  JOHN J. JONES</p>		<p>AGE                  45</p>		<p>SEX                  Male</p>		<p>RACE                  White</p>	
<p>DATE OF DEATH                  Jan 15 1901</p>		<p>TIME OF DEATH                  10:30 AM</p>		<p>PLACE OF DEATH                  Home</p>		<p>CITY                  Baltimore</p>	
<p>CAUSE OF DEATH                  Heart Disease</p>		<p>IMMEDIATE CAUSE                  Myocardial Infarction</p>		<p>INTERMEDIATE CAUSE                  Coronary Atherosclerosis</p>		<p>FINAL CAUSE                  Atherosclerosis</p>	
<p>DATE OF BIRTH                  Dec 10 1855</p>		<p>PLACE OF BIRTH                  Maryland</p>		<p>EDUCATION                  High School</p>		<p>OCCUPATION                  Clerk</p>	
<p>DATE OF MARRIAGE                  May 1 1880</p>		<p>NAME OF SPOUSE                  Mary J. Jones</p>		<p>DATE OF INTERVIEW                  Jan 16 1901</p>		<p>NAME OF INTERVIEWER                  Dr. J. H. Smith</p>	
<p>DATE OF BURIAL                  Jan 17 1901</p>		<p>PLACE OF BURIAL                  St. Mary's Church</p>		<p>NAME OF MINISTER                  Rev. J. H. Smith</p>		<p>NAME OF FUNERAL HOME                  Jones &amp; Co.</p>	
<p>DATE OF EXAMINATION                  Jan 15 1901</p>		<p>PLACE OF EXAMINATION                  Home</p>		<p>NAME OF PHYSICIAN                  Dr. J. H. Smith</p>		<p>NAME OF NURSE                  Mrs. J. H. Smith</p>	
<p>DATE OF CERTIFICATE                  Jan 16 1901</p>		<p>PLACE OF CERTIFICATE                  Baltimore</p>		<p>NAME OF REGISTRAR                  J. H. Smith</p>		<p>NAME OF CLERK                  M. J. Jones</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12808

12795

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>7510 Hawthorne St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Franklin</u> Last <u>Alvey</u>	4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Edward T. Alvey</u>		14. MOTHER'S MAIDEN NAME <u>Rose C. Hancock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>217-07-8906</u>	
17. INFORMANT <u>Myrtle Alvey - same address as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral compression &amp; necrosis.</u> DUE TO <u>900.6</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subdural and epidural hemorrhage</u> DUE TO <u>Fracture of skull</u> (c) <u>Fracture of skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Blow on head caused by fall down stairs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blow on head caused by fall down stairs.</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:50</u> Hour <u>a.m.</u> <u>11-7-1958</u> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School</u>	20f. (City or town) <u>Bradbury</u> (County) <u>Pr. Geo</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u>		DATE SIGNED <u>11-10-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 12, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	
								</																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12809

CERTIFICATE OF DEATH

Reg. Dist. No.

12796

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hgts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capitol Heights,	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5801 F St.		d. STREET ADDRESS 5801 F St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Antonio		4. DATE OF DEATH Month Day Year Nov. 24 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 27 Aug. 1891
9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) had hat concession at		10b. KIND OF BUSINESS OR INDUSTRY Statler Hotel in D.C.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-24-2547	
17. INFORMANT Mary Antonio		Address 5801 F St. Cap. Hgts. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Primary Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/9, 1958, to 11/24, 1958, that I last saw the deceased alive on Nov 19, 1958, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HARRY M. CARLTON, M.D. 1816 R. St. N.W. Wash. DC. 11/24/58 PHYSICIAN'S NAME (Type) HARRY M. CARLTON 1816 R. St. N.W. Wash. DC.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Nov. '58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funera 1		ADDRESS Home 4 & Mass av. N. E.	
24a. REC'D BY REGISTRAR NOV 28 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Fraus	

# CERTIFICATE OF DEATH

STATEMENT OF HEALTH - BALANCE 10

NAME		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
EDUCATION		MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

## 12810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G237 1-7-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md	c. LENGTH OF STAY IN 1b transient	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore & Ohio R.R. Tracks		d. STREET ADDRESS 4804 Tuckerman St	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELIZABETH ROSE BALINOVIC		4. DATE OF DEATH Month Day Year November 21, 19 58-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1907
9. AGE (In years and birthday) 32 1/2 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY U S A		13. FATHER'S NAME Andrew Burless	
14. MOTHER'S MAIDEN NAME Pet Mary Budner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 578/83199		17. INFORMANT Address Peter Balinovic Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 802x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma, multiple and severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by passenger train	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8.19 11/21/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks	20f. (City or town) (County) (State) Riverdale Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 22, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-24-58	22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colman Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

1. STATE  
2. COUNTY

3. NAME OF DECEASED  
4. SEX

5. AGE

6. OCCUPATION

7. PLACE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. MANNER OF DEATH

13. NAME OF PHYSICIAN

14. NAME OF SURGEON

15. NAME OF PATHOLOGIST

16. NAME OF FORENSIC EXAMINER

17. NAME OF JURY

18. NAME OF JUDGE

19. NAME OF DISTRICT ATTORNEY

20. NAME OF CLERK

21. NAME OF JURY

22. NAME OF JUDGE

23. NAME OF DISTRICT ATTORNEY

24. NAME OF CLERK

25. NAME OF JURY

26. NAME OF JUDGE

27. NAME OF DISTRICT ATTORNEY

28. NAME OF CLERK

29. NAME OF JURY

30. NAME OF JUDGE

31. NAME OF DISTRICT ATTORNEY

32. NAME OF CLERK

33. NAME OF JURY

34. NAME OF JUDGE

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12860

## CERTIFICATE OF DEATH

12800

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>PR. GEO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PR. GEO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>MARLBORO</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARLBORO</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SERVICE LANE</u>				STREET ADDRESS (If rural give location) <u>SERVICE LANE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY ELIZABETH BARNETT</u>				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>1</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>2-20-1939</u>	9. AGE last birthday <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>ALEXANDER BARNETT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SPRIGGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>—</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
201X IMMEDIATE CAUSE (A) <u>Hodgkin's Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Conjunctive Heart Failure</u>				<u>Two days</u>			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James B. Nusser</u>				ADDRESS (Street, city, town, state) <u>Upper Marlboro Md (11-1-58)</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/5/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>			



# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF FUNERAL HOME		15. NAME OF BURIAL PLACE	
16. NAME OF WITNESS		17. NAME OF WITNESS		18. NAME OF WITNESS	
19. NAME OF WITNESS		20. NAME OF WITNESS		21. NAME OF WITNESS	
22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	
25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS	
28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS	
34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS	
37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS	
40. NAME OF WITNESS		41. NAME OF WITNESS		42. NAME OF WITNESS	
43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	
49. NAME OF WITNESS		50. NAME OF WITNESS		51. NAME OF WITNESS	
52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS	
55. NAME OF WITNESS		56. NAME OF WITNESS		57. NAME OF WITNESS	
58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS	
64. NAME OF WITNESS		65. NAME OF WITNESS		66. NAME OF WITNESS	
67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS	
70. NAME OF WITNESS		71. NAME OF WITNESS		72. NAME OF WITNESS	
73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS	
79. NAME OF WITNESS		80. NAME OF WITNESS		81. NAME OF WITNESS	
82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS	
85. NAME OF WITNESS		86. NAME OF WITNESS		87. NAME OF WITNESS	
88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS	
94. NAME OF WITNESS		95. NAME OF WITNESS		96. NAME OF WITNESS	
97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS	
100. NAME OF WITNESS		101. NAME OF WITNESS		102. NAME OF WITNESS	

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BOSTON  
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12811

## CERTIFICATE OF DEATH

12801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 hr. 25 min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>3805 Powhatan Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Beall</b>			4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-07</b>		9. AGE (In years lost birthday) <b>51 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hetch Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>			
13. FATHER'S NAME <b>Franklin Cockrell</b>			14. MOTHER'S MAIDEN NAME <b>Frances P. McDonald</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Michael G. Beall</b> Address <b>Same as #2</b> <b>Sub - A. B. Howard - Hammock House</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330X</b> <b>Auto Leeb-Croderoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-1</b> , 19 <b>58</b> , to <b>11-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-2</b> , 19 <b>58</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b> DATE SIGNED <b>11-3-58</b>							
ACTUAL SIGNATURE <b>A. Deitz</b>		M.D. <b>Hyattsville, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Aaron Deitz</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F.D. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Calmar Manor Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Dorsch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 6 '58</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE ATTACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

CERTIFICATE OF DEATH

1934

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CONTINUED

100-100000

EXHIBIT

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12802

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>8 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5011 38th Avenue</b>			d. STREET ADDRESS <b>5011 38th Avenue</b>		
3. NAME OF DECEASED (Type or print) <b>George Thomas Bielonis</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>21,</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-09</b>		9. AGE (In years last birthday) <b>48 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>George Bielonis</b>			14. MOTHER'S MAIDEN NAME <b>Mary Gwasditis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.2</b>		16. SOCIAL SECURITY NO. <b>188-09-1381</b>		17. INFORMANT Address <b>Mary Bielonis; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>891.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carbon monoxide poisoning</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Asphyxia due to inhalation of fumes from automobile.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11- 21- 58</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (garage)</b>	
				20f. (City or town) (County) (State) <b>Hyattsville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 22, 1958</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 25, 1958</b>		22c. NAME OF CEMETERY OR INTERMENT <b>Arlington National</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>			24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of Death	Stevenville
Age	5 years
Sex	Female
Color	White
Marital Status	Single
Occupation	None
Usual Residence	Stevenville, Mississippi
Date of Death	October 21, 1938
Time of Death	11:30 PM
Place of Death	Stevenville, Mississippi
Signature of Medical Examiner	John T. Holmes, M.D.
Date of Signature	November 22, 1938



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

CERTIFICATE OF DEATH

Reg. Dist. No.

12803

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Maryland.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 6911 Carleton Terrace	
3. NAME OF DECEASED (Type or print) First MIDDLE Last GLADYS GARCIA BOLLINGER		4. DATE OF DEATH Month Day Year Nov 15, 19 58-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1897
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Public school	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank King		14. MOTHER'S MAIDEN NAME Savilla ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Philip H Bollinger		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 13, 1958, to Nov 15, 1958, and that I last saw the deceased alive on Nov 14, 1958, and that death occurred at 6 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Hyattsville, Md. 11-15-58	
ACTUAL SIGNATURE Leonard Hays		M.D. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Leonard Hays		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pt. Geo</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. LENGTH OF STAY in 1b <i>DDA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenarden</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Gen Hosp</i>			e. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Mary</i>			4. DATE OF DEATH Month <i>11</i> Day <i>8</i> Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-18</i>		9. AGE (In years last birthday) <i>40</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U-S-A</i>		13. FATHER'S NAME <i>Olto Paul Wheeler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Washington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Wheeler; Glen Arden, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage &amp; shock</i> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Severence of thoracic aorta</i> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Occupant of a parked auto - struck by another Automobile</i>			
20c. TIME OF INJURY Month, Day, Year <i>4-04-11-8 1958</i>		20d. INJURY OCCURRED <i>White</i> <input type="checkbox"/> <i>Not white</i> <input checked="" type="checkbox"/> <i>at work</i> <input type="checkbox"/> <i>Not at work</i> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	
20f. City or town <i>Landom - Pt Geo - Md</i>		(County)		(State)	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John J. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>John T. Maloney M.D</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>11-8-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-12-58</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Family</i>	
22d. LOCATION (City, town, or county) <i>Woodmore Md</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Schmitt</i>		ADDRESS <i>467 N St NE</i>		24a. REC'D BY REGISTRAR <i>13 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraw</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12796

## CERTIFICATE OF DEATH

## Reg. Dist. No. 12805

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince George's</b></span>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>			c. LENGTH OF STAY IN 1b <b>15</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5323 Greenway Drive</b>				d. STREET ADDRESS <b>5323 Greenway Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Beatrice</b> Middle <b>Bruno</b> Last <b>Bruno</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>13,</b> Year <b>19 58-</b>											
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan 31, 1884</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>Italy</b>								
<b>13. FATHER'S NAME</b> <b>John Bevalaque</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna ?</b>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>none</b>		<b>17. INFORMANT</b> Address <b>Rose Bruno Hyattsville Maryland.</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <b>11-12-58</b> <b>to</b> <b>11-13-58</b> <b>that I last saw the deceased alive on</b> <b>11-12-58</b> <b>and that death occurred at</b> <b>49</b> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <b>Leonard Hays</b> <b>M.D.</b> <b>Hyattsville Md.</b> <b>DATE SIGNED</b> <b>PHYSICIAN'S NAME (Type)</b> <b>Dr. Leonard Hays</b> <b>Hyattsville, Maryland.</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>22b. DATE THEREOF</b> <b>Nov 15, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt Olivet Cemetery</b>			<b>22d. LOCATION (City, town, or county)</b> (State) <b>Washington D. C.</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>F. Gasch's Sons Hyattsville, Maryland.</b>					<b>24a. REC'D BY REGISTRAR</b> DATE <b>NOV 17 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ARIZONA STATE DEPARTMENT OF HEALTH - BALTIMORE 15

10

100

12814 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>36</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Bruzzese</b>				4. DATE OF DEATH Month Day Year <b>November 9 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-14-86</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Mike Bruzzese</b>				14. MOTHER'S MAIDEN NAME <b>Concetta Zurjolo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Michael J. Bruzzese</b>				Address <b>805 48th A ve.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacter Intestinal Hemorrhage</b> 581.0 DUE TO (b) <b>Cirrhosis of Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>Nov 9, 1958</b> , that I last saw the deceased alive on <b>November 9, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Brainin M.D.</b>				ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>			
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>				DATE SIGNED <b>11/9/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
22d. LOCATION (City, town, or county) <b>Bladensburg,</b>				(State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				ADDRESS <b>300 4th st. N.E.</b>		24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

CERTIFICATE OF DEATH

1914

NAME OF DECEASED  
JAMES J. CONNELLEY  
AGE  
38  
SEX  
M  
RACE  
W  
DATE OF DEATH  
JAN 12 1914  
PLACE OF DEATH  
NEW YORK CITY

LOCALITY OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF DEATH

PLACE OF DEATH

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12794

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12807

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8914 Baltimore Avenue</b>		d. STREET ADDRESS <b>8914 Baltimore Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>TAPLEY WILLIAM BRYANT</b>		4. DATE OF DEATH <b>November 1st, 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4th, 1867</b>
9. AGE (In years last birthday) <b>91 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bryant</b>		14. MOTHER'S MAIDEN NAME <b>Clemetine Gutridge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-18-4868D</b>	
17. INFORMANT <b>Taylor J. Bryant, 8914 Baltimore Ave.,</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Gente congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John J. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <b>11/4/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

## CERTIFICATE OF DEATH

Reg. Dist. No.

12808

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATEAUVILLE</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 HRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WOODLAWN (HYATTSVILLE RD)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL</u>		d. STREET ADDRESS <u>7103 GREENVALE PARKWAY</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>GREGORY</u> Last <u>CARON</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 12, 1892</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIFICIAL LIMB MFG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	11. BIRTHPLACE (State or foreign country) <u>ITALY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>VICTOR CARON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>	
17. INFORMANT <u>VELMA B CARON</u>		Address <u>WOODLAWN MD, 7103 GREENVALE PARKWAY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X CEREBRAL HEMORRAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hours</u> <u>5 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10 JUL 1956</u> , to <u>11 NOV 1958</u> , that I last saw the deceased alive on <u>11 NOV 1958</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas G. Maloney</u>		ADDRESS (Street, city or town, state) <u>4814-71ST AVE LANDOVER HILLS MD</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u>		DATE SIGNED <u>11 NOV 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>COLMAR MARION RD 600 Co, MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co. Riverdale, MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1910

1910

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNIC ORIGIN

RECORDED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO BE FILLED BY THE REGISTRAR OF VITALS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12816  
CERTIFICATE OF DEATH

12809  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b>	
f. STREET ADDRESS <b>6418 L Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Esther Carter</b>		4. DATE OF DEATH Month Day Year <b>November 1 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>George Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Lena Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Richard Carter Husband</b>		Address <b>Address Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-vascular renal</b> DUE TO (c) <b>Ischem</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 23, 1958</b> , to <b>November 1, 1958</b> , that I last saw the deceased alive on <b>November 1, 1958</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b>		ADDRESS (Street, city or town, state) <b>5432 DUFFENS CHAPEL Rd</b>	
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		DATE SIGNED <b>11/1/58</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>11-5-58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Benning Rd SE, DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S Washington</b>		ADDRESS <b>467 N st NW</b>	
24a. RECEIVED BY REGISTRAR <b>NOV 5 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

CERTIFICATE OF DEATH

RECORD

1/1

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12861

## CERTIFICATE OF DEATH

Reg. Dist. No.

12810

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3714-43rd Ave.</u>		d. STREET ADDRESS <u>3714-43rd Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Peter Conlan</u>		4. DATE OF DEATH <u>Nov. 19th 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer, Retired U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Albany, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Conlan</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Sweeney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give <u>5/1/18-8/16/19</u> dates of service)	
16. SOCIAL SECURITY NO. <u>5418-81619</u>		17. INFORMANT <u>Robert J. Conlan</u> Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. carcinoma atosis</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma sigmoid colon</u> DUE TO (c) <u>Dist. Metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-17-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-9</u> , 19 <u>57</u> , to <u>11/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>58</u> , and that death occurred at <u>6:21</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11/19/58</u> DATE SIGNED			
ACTUAL SIGNATURE <u>George J. Hageage</u> M.D. <u>3712-38th</u>		22. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
PHYSICIAN'S NAME (Type) <u>George J. Hageage</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> ADDRESS <u>Ind.</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>



CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF DEATH <i>Jan 15 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>UNDERLYING CAUSE <i>Arteriosclerosis</i></p>	
<p>DATE OF BIRTH <i>Jan 15 1873</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>OCCUPATION <i>Teacher</i></p>		<p>RELIGION <i>Methodist</i></p>		<p>Usual Residence <i>123 Main St. Baltimore, Md.</i></p>	
<p>Signature of Physician <i>John Doe</i></p>		<p>Signature of Registrar <i>John Doe</i></p>		<p>Signature of Coroner <i>John Doe</i></p>	

RECEIVED  
JAN 16 1918  
BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12817

CERTIFICATE OF DEATH

12811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George</b>				d. STREET ADDRESS <b>Box 15 A Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucile</b>		First <b>Lucile</b> Middle <b>Coplan</b> Last <b>Coplan</b>		4. DATE OF DEATH <b>Nov 20 1958</b>		Month <b>Nov</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-1909</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>18</b> Hours <b>18</b> Min. <b>49</b>		IF UNDER 24 HRS Months <b>11</b> Days <b>18</b> Hours <b>18</b> Min. <b>49</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CASHIER.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CAB Co.</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 28 9987</b>		17. INFORMANT <b>MRS. IVY M GORMLEY. BOX 15 A, ROUTE 1. UPPER MARLBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis.</b> DUE TO (c) <b>Chronic Pyelonephritis.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>16 Nov 58</b> , <b>1958</b> , to <b>19 Nov 58</b> , that I last saw the deceased alive on <b>19 Nov 58</b> , and that death occurred at <b>12-15 A</b> , from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE <b>William M Dixon</b> M.D. <b>Prince George</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL CEM</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES VO MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>				24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Verity

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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IN THE CITY OF BALTIMORE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12812**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Brentwood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3800 Bunker Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Thornton</b> Last <b>Cornwell</b>				4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2-12-1899</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Disabled Veteran</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edgar M. Cornwell</b>				14. MOTHER'S MAIDEN NAME <b>Annie Posey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>		17. INFORMANT <b>Evelyn Tanner; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. M. loney</b>				DATE SIGNED <b>November 30, 1958</b>			
EXAMINER'S NAME (Type) <b>John T. M. loney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Dec 3, 1958</b>		<b>Fort Lincoln Cemetery</b>		<b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		24b. REGISTRAR'S SIGNATURE <i>C. S. Jones</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12862

## CERTIFICATE OF DEATH

12813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Unknown</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AF Base</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital, Andrews</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fayetteville</b> 70x-3			
f. STREET ADDRESS <b>5403 Dairy Road</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Leo</b> Last <b>Costello</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14 1918</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Air Force</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Martin Costello</b>				14. MOTHER'S MAIDEN NAME <b>unknown, Donohue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>41-45 &amp; 50-53</b>				16. SOCIAL SECURITY NO. <b>224-52-1851</b>		17. INFORMANT <b>Wife - Mrs Virginia Costello</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of Liver with Ascites</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>24 Oct</b> , 19 <b>58</b> , to <b>17 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>16 Nov</b> , 19 <b>58</b> , and that death occurred at <b>0855a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 Nov 58</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Bernard T Clowdus</b> M.D.				USAF Hospital, Andrews			
PHYSICIAN'S NAME (Type) <b>BERNARD CLOWDUS, CAPT, USAF (MD)</b>				Andrews AF Base, Washington 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Linardi Funeral Home</b>				24a. REC'D BY REGISTRAR <b>816 H St. N.E. WASHINGTON 2, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>DATE NOV 19 '58</b>	

CERTIFICATE OF DEATH

1952

NAME OF DECEASED John Doe		SEX Male	
AGE 34 years		DATE OF BIRTH January 1, 1918	
PLACE OF BIRTH Baltimore, Maryland		US AIR FORCE	
OCCUPATION Pilot		DATE OF DEATH December 1, 1952	
CAUSE OF DEATH Myocardial Infarction		PLACE OF DEATH Baltimore, Maryland	
SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		SIGNATURE OF REGISTRAR J. H. Smith, M.D.	

12863

## CERTIFICATE OF DEATH

12814

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ACCOKEEK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 360 ROUTE #1</u>				d. STREET ADDRESS <u>BOX 360 ROUTE #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD LELAND DARLING</u>				4. DATE OF DEATH Month Day Year <u>NOV 27, 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 23, 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARINE ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>EMB. DAIRY</u>		11. BIRTHPLACE (State or foreign country) <u>GIRARD ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN GRAHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WAR I.</u>				16. SOCIAL SECURITY NO. <u>163-01-3461</u>		17. INFORMANT Address <u>Mrs Lillian R. DARLING ACCOKEEK, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Fibrosis</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema; Cor Pulmonale</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1953</u> to <u>Nov 27, 1958</u> that I last saw the deceased alive on <u>11-27-58</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Eugene J. Yarkoff M.D.</u> 20 Min. N.E.							
PHYSICIAN'S NAME (Type) <u>E. J. Yarkoff M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-1-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Breese Hill, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. Chambers Co. Inc., Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12819**  
**CERTIFICATE OF DEATH**

**12815**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>20 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuxedo</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>5200 Tuxedo Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>B.</b> Last <b>Davidson</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 21, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Theodore B. Lipscomb</b>				14. MOTHER'S MAIDEN NAME <b>Annie Barker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ewell Mohler</b> Address <b>Same Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Circled Carcinoma of the stomach</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Oct. 29, 1958</b> , to <b>Nov. 18, 1958</b> , that I last saw the deceased alive on <b>Nov. 18, 1958</b> , and that death occurred at <b>9:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1726 Eye St., N.W.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Saul Schwartzback</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>Dr. Saul Schwartzback</b> <b>Washington, D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Bladensburg, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>Johns Hopkins</u></p>		<p>6. Date of death: <u>Jan 20, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Johns Hopkins</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 20, 1945</u></p>		<p>12. Place of registration: <u>Johns Hopkins</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12820 CERTIFICATE OF DEATH

12816

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>13012 Laurel Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Luther Robert Dowden</u>		4. DATE OF DEATH Month Day Year <u>Nov 11 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 3 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charlie Dowden</u>		14. MOTHER'S MAIDEN NAME <u>Ida Virginia Thayne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Esther V. Sullivan Chesley, Md.</u>	
17. INFORMANT <u>Mr. Esther V. Sullivan Chesley, Md.</u>		Address <u>13012 Laurel Ave</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pul t.b. (chi.)</u> DUE TO (c) <u>4 1/2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 6</u> , 19 <u>57</u> , to <u>Nov 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. R. Fenton</u>		ADDRESS (Street, city or town, state) <u>1801 Eye St NW</u>	
PHYSICIAN'S NAME (Type) <u>E. R. Fenton</u>		DATE SIGNED <u>Nov 6 DE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Warrington</u>		22d. LOCATION (City, town, or county) (State) <u>Warrington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u>		ADDRESS <u>Wash D. C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Date of filing	
13. Place of birth		14. Date of arrival in U.S.		15. Date of last visit		16. Date of death		17. Date of death		18. Date of death	
19. Date of death		20. Date of death		21. Date of death		22. Date of death		23. Date of death		24. Date of death	
25. Date of death		26. Date of death		27. Date of death		28. Date of death		29. Date of death		30. Date of death	
31. Date of death		32. Date of death		33. Date of death		34. Date of death		35. Date of death		36. Date of death	
37. Date of death		38. Date of death		39. Date of death		40. Date of death		41. Date of death		42. Date of death	
43. Date of death		44. Date of death		45. Date of death		46. Date of death		47. Date of death		48. Date of death	
49. Date of death		50. Date of death		51. Date of death		52. Date of death		53. Date of death		54. Date of death	
55. Date of death		56. Date of death		57. Date of death		58. Date of death		59. Date of death		60. Date of death	
61. Date of death		62. Date of death		63. Date of death		64. Date of death		65. Date of death		66. Date of death	
67. Date of death		68. Date of death		69. Date of death		70. Date of death		71. Date of death		72. Date of death	
73. Date of death		74. Date of death		75. Date of death		76. Date of death		77. Date of death		78. Date of death	
79. Date of death		80. Date of death		81. Date of death		82. Date of death		83. Date of death		84. Date of death	
85. Date of death		86. Date of death		87. Date of death		88. Date of death		89. Date of death		90. Date of death	
91. Date of death		92. Date of death		93. Date of death		94. Date of death		95. Date of death		96. Date of death	
97. Date of death		98. Date of death		99. Date of death		100. Date of death		101. Date of death		102. Date of death	
103. Date of death		104. Date of death		105. Date of death		106. Date of death		107. Date of death		108. Date of death	
109. Date of death		110. Date of death		111. Date of death		112. Date of death		113. Date of death		114. Date of death	
115. Date of death		116. Date of death		117. Date of death		118. Date of death		119. Date of death		120. Date of death	
121. Date of death		122. Date of death		123. Date of death		124. Date of death		125. Date of death		126. Date of death	
127. Date of death		128. Date of death		129. Date of death		130. Date of death		131. Date of death		132. Date of death	
133. Date of death		134. Date of death		135. Date of death		136. Date of death		137. Date of death		138. Date of death	
139. Date of death		140. Date of death		141. Date of death		142. Date of death		143. Date of death		144. Date of death	
145. Date of death		146. Date of death		147. Date of death		148. Date of death		149. Date of death		150. Date of death	
151. Date of death		152. Date of death		153. Date of death		154. Date of death		155. Date of death		156. Date of death	
157. Date of death		158. Date of death		159. Date of death		160. Date of death		161. Date of death		162. Date of death	
163. Date of death		164. Date of death		165. Date of death		166. Date of death		167. Date of death		168. Date of death	
169. Date of death		170. Date of death		171. Date of death		172. Date of death		173. Date of death		174. Date of death	
175. Date of death		176. Date of death		177. Date of death		178. Date of death		179. Date of death		180. Date of death	
181. Date of death		182. Date of death		183. Date of death		184. Date of death		185. Date of death		186. Date of death	
187. Date of death		188. Date of death		189. Date of death		190. Date of death		191. Date of death		192. Date of death	
193. Date of death		194. Date of death		195. Date of death		196. Date of death		197. Date of death		198. Date of death	
199. Date of death		200. Date of death		201. Date of death		202. Date of death		203. Date of death		204. Date of death	
205. Date of death		206. Date of death		207. Date of death		208. Date of death		209. Date of death		210. Date of death	
211. Date of death		212. Date of death		213. Date of death		214. Date of death		215. Date of death		216. Date of death	
217. Date of death		218. Date of death		219. Date of death		220. Date of death		221. Date of death		222. Date of death	
223. Date of death		224. Date of death		225. Date of death		226. Date of death		227. Date of death		228. Date of death	
229. Date of death		230. Date of death		231. Date of death		232. Date of death		233. Date of death		234. Date of death	
235. Date of death		236. Date of death		237. Date of death		238. Date of death		239. Date of death		240. Date of death	
241. Date of death		242. Date of death		243. Date of death		244. Date of death		245. Date of death		246. Date of death	
247. Date of death		248. Date of death		249. Date of death		250. Date of death		251. Date of death		252. Date of death	
253. Date of death		254. Date of death		255. Date of death		256. Date of death		257. Date of death		258. Date of death	
259. Date of death		260. Date of death		261. Date of death		262. Date of death		263. Date of death		264. Date of death	
265. Date of death		266. Date of death		267. Date of death		268. Date of death		269. Date of death		270. Date of death	
271. Date of death		272. Date of death		273. Date of death		274. Date of death		275. Date of death		276. Date of death	
277. Date of death		278. Date of death		279. Date of death		280. Date of death		281. Date of death		282. Date of death	
283. Date of death		284. Date of death		285. Date of death		286. Date of death		287. Date of death		288. Date of death	
289. Date of death		290. Date of death		291. Date of death		292. Date of death		293. Date of death		294. Date of death	
295. Date of death		296. Date of death		297. Date of death		298. Date of death		299. Date of death		300. Date of death	

1 *7*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12821 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12817  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
c. LENGTH OF STAY IN 1b <u>10 hours</u>		d. STREET ADDRESS <u>821 59 Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Dowling</u> Last <u>Dowling</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/05</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Sidney J. Macpherson</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Kendley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George Dowling Husband</u>		Address <u>Address Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE (CARDIOVASCULAR) DISEASE 5 YRS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 4</u> , 19 <u>58</u> , to <u>November 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 5</u> , 19 <u>58</u> , and that death occurred at <u>9:45 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Bmeal</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>11/5/58</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAL</u>		<u>MT Rainier MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ardenwood</u>		22d. LOCATION (City, town, or county) (State) <u>LA Major Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mattingly</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 10 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Robert G. Mattingly</u>			

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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

## CERTIFICATE OF DEATH

12818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glennedale, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glennedale, Maryland.</b>	
c. LENGTH OF STAY IN 1b <b>25 years</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glennedale Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Glennedale Road</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>Duley</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Freight Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Cornelius Duley</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Mary M Duley</b>		Address <b>Glennedale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1950</b> to <b>Nov. 2, 1958</b> , that I last saw the deceased alive on <b>Nov. 1, 1958</b> , and that death occurred at <b>999</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b>		ADDRESS (Street, city or town, state) <b>R. D. Bowie Rd</b>	
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		DATE SIGNED <b>11/2/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 5, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1968

U.S.A.

U.S.A.

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Date of birth</p>		<p>4. Place of birth</p>	
<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	
<p>13. Signature of funeral director</p>		<p>14. Signature of undertaker</p>	
<p>15. Signature of cemetery</p>		<p>16. Signature of burial</p>	
<p>17. Signature of crematorium</p>		<p>18. Signature of cremation</p>	
<p>19. Signature of interment</p>		<p>20. Signature of exhumation</p>	
<p>21. Signature of reinterment</p>		<p>22. Signature of disinterment</p>	
<p>23. Signature of removal</p>		<p>24. Signature of return</p>	
<p>25. Signature of other</p>		<p>26. Signature of other</p>	
<p>27. Signature of other</p>		<p>28. Signature of other</p>	
<p>29. Signature of other</p>		<p>30. Signature of other</p>	
<p>31. Signature of other</p>		<p>32. Signature of other</p>	
<p>33. Signature of other</p>		<p>34. Signature of other</p>	
<p>35. Signature of other</p>		<p>36. Signature of other</p>	
<p>37. Signature of other</p>		<p>38. Signature of other</p>	
<p>39. Signature of other</p>		<p>40. Signature of other</p>	
<p>41. Signature of other</p>		<p>42. Signature of other</p>	
<p>43. Signature of other</p>		<p>44. Signature of other</p>	
<p>45. Signature of other</p>		<p>46. Signature of other</p>	
<p>47. Signature of other</p>		<p>48. Signature of other</p>	
<p>49. Signature of other</p>		<p>50. Signature of other</p>	
<p>51. Signature of other</p>		<p>52. Signature of other</p>	
<p>53. Signature of other</p>		<p>54. Signature of other</p>	
<p>55. Signature of other</p>		<p>56. Signature of other</p>	
<p>57. Signature of other</p>		<p>58. Signature of other</p>	
<p>59. Signature of other</p>		<p>60. Signature of other</p>	
<p>61. Signature of other</p>		<p>62. Signature of other</p>	
<p>63. Signature of other</p>		<p>64. Signature of other</p>	
<p>65. Signature of other</p>		<p>66. Signature of other</p>	
<p>67. Signature of other</p>		<p>68. Signature of other</p>	
<p>69. Signature of other</p>		<p>70. Signature of other</p>	
<p>71. Signature of other</p>		<p>72. Signature of other</p>	
<p>73. Signature of other</p>		<p>74. Signature of other</p>	
<p>75. Signature of other</p>		<p>76. Signature of other</p>	
<p>77. Signature of other</p>		<p>78. Signature of other</p>	
<p>79. Signature of other</p>		<p>80. Signature of other</p>	
<p>81. Signature of other</p>		<p>82. Signature of other</p>	
<p>83. Signature of other</p>		<p>84. Signature of other</p>	
<p>85. Signature of other</p>		<p>86. Signature of other</p>	
<p>87. Signature of other</p>		<p>88. Signature of other</p>	
<p>89. Signature of other</p>		<p>90. Signature of other</p>	
<p>91. Signature of other</p>		<p>92. Signature of other</p>	
<p>93. Signature of other</p>		<p>94. Signature of other</p>	
<p>95. Signature of other</p>		<p>96. Signature of other</p>	
<p>97. Signature of other</p>		<p>98. Signature of other</p>	
<p>99. Signature of other</p>		<p>100. Signature of other</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12819

12822

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		c. LENGTH OF STAY IN TB <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Duran</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 2, 1958</b>
9. AGE (In years lost birthday) yrs. <b>3</b> Months <b>7</b> Days <b>45</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>PETER DURAN</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Duran TIPPETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Elsie</b>		Address <b>Mother Address Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 2, 19 58</b> , to <b>November 5, 19 58</b> , that I last saw the deceased alive on <b>November 5, 19 58</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin</b>		ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		DATE SIGNED <b>11/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt Olived</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Dc</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Esq</b>		ADDRESS <b>517 11th St SE</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

2077409XVO

CERTIFICATE OF DEATH

1933

REG. NO. 100

DATE OF DEATH	10/10/33
TIME OF DEATH	10:00 AM
PLACE OF DEATH	HOME
CAUSE OF DEATH	HEART DISEASE

*Handwritten signature*  
J. M. [illegible]  
[illegible]  
[illegible]

*[Redacted area]*

*Handwritten signature*  
J. M. [illegible]  
[illegible]  
[illegible]

*Handwritten signature*  
J. M. [illegible]  
[illegible]  
[illegible]

*Handwritten signature*  
J. M. [illegible]  
[illegible]  
[illegible]

*Handwritten signature*  
J. M. [illegible]  
[illegible]  
[illegible]

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12820

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>	c. LENGTH OF STAY IN 1b <u>14 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>Missouri Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest G. Enslow</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1881</u>
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Danvers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. &amp;</u>	
13. FATHER'S NAME <u>Thomas Worthington Enslow</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kendall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-7965</u>	
17. INFORMANT <u>May E. Hodges</u>		Address <u>5611 Allen Ave NW</u> <u>Washington 23, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 11, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl. Suitland Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Bros</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '58</u>	
ADDRESS <u>1661-94 Hope Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**12797**

**CERTIFICATE OF DEATH**

Reg. Dist. No.

**12821**

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4209 Jefferson St</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville, Md.</b>	
d. STREET ADDRESS <b>4209 Jefferson St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>K.</b> Last <b>Ervin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 58-</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25, 1876</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Weeks</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Catherine Webb</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>J. Dallas Ervin</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1958</b> to <b>11-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-5</b> , 19 <b>58</b> , and that death occurred at <b>noon</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b> DATE SIGNED <b>Arthur L. Hays</b>			
ACTUAL SIGNATURE <b>Leonard Hays</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr Leonard Hays</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 10, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12865

## CERTIFICATE OF DEATH

## Reg. Dist. No. 12822

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b <u>6 months &amp; 19 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3451 17th St., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alice</u> Middle <u>-</u> Last <u>Finley</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>28</u> Year <u>19 58</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11/3/93 or 11/4/94</u>		<b>9. AGE</b> (In years last birthday) <u>64 or yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		<b>IF UNDER 24 HRS.</b> Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Alabama</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>F. L. Fossick</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary O'Reilly</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Information secured through Chest Clinic, 14th and Upshur Sts., N. W., Washington, D. C., by Miss Myer, Public Health Nurse</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>492X</u> IMMEDIATE CAUSE (a) <u>Pneumonitis, right lung, etiology undetermined, with secondary infection bullous cyst</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Pulmonary tuberculosis</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>5/9</u> , 19 <u>58</u> , <b>to</b> <u>11/28</u> , 19 <u>58</u> , <b>that I last saw the deceased alive on</b> <u>11/27</u> , 19 <u>58</u> , <b>and that death occurred at</b> <u>12:15AM</u> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <u>Glenn Dale Hospital</u> <b>DATE SIGNED</b> <u>11/28/58</u> <b>ACTUAL SIGNATURE</b> <u>Moe Weiss</u> <b>M.D.</b> <u>Glenn Dale Hospital</u> <b>PHYSICIAN'S NAME (Type)</b> <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>11/28/58</u>				<b>22b. DATE THEREOF</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Tusculumba Alabama</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. H. Vines Co.</u> <b>ADDRESS</b> <u>2901-14 4th St. N.W. D.C.</u>														<b>24a. REC'D BY REGISTRAR</b> <u>DEC 2 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Froust</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

WILLIAM  
EDMOND

NAME		WILLIAM EDMOND	
AGE		25	
SEX		M	
RACE		W	
DATE OF BIRTH		JAN 1 1900	
PLACE OF BIRTH		NEW YORK	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF REGISTRAR		[Signature]	
DATE		JAN 1 1900	
PLACE		ALBANY, N. Y.	

# CERTIFICATE OF DEATH

Reg. Dist. No.

12823

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kent Village</b>		c. LENGTH OF STAY IN 1b <b>KENT VILLAGE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7204 Hawthorne Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AMY</b> Middle <b>Fitzgerald</b> Last <b>1958</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 21 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON DC</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS CRABTREE</b>		14. MOTHER'S MAIDEN NAME <b>PRISCILLA HARRISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MR. BEFANCE MERCHANT</b>	
17. INFORMANT <b>9307 WELLINGTON ST SEABROOK MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Peripheral vascular failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>8 yrs.</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>9:45</b> a.m. Month <b>19</b> Day <b>19</b> Year <b>1958</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 1937</b> , to <b>Nov. 8, 1958</b> , that I last saw the deceased alive on <b>11/6/58</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1844 Col Rd NW</b> DATE SIGNED <b>Nov 12 '58</b>	
ACTUAL SIGNATURE <b>E.H. Aschenbach</b> M.D.		PHYSICIAN'S NAME (Type) <b>E.H. Aschenbach</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/12/1958</b>		22b. DATE THEREOF <b>CEEDAR HILL</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Swifton, Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ph. S. S. S.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
24b. REGISTRAR'S SIGNATURE <b>NOV 12 '58</b>		24c. DATE	





1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENN.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u> 75x.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Race track</u>		d. STREET ADDRESS <u>101 S. 41ST. ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>J</u> Last <u>Flood</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1904</u>
9. AGE (in years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. POLICE</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH FLOOD</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SWEENEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOSEPH R. FLOOD</u>		Address <u>3008 N. 4th - Harrisburg Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Public</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Givett</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Phila Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>	
ADDRESS <u>Catonville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12-24

MAKING STATEMENT OF HEALTH - BATHING IS

1922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
NEW YORK

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF EXAMINER

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF STATE CLERK

22. SIGNATURE OF U.S. MARSHAL

23. SIGNATURE OF U.S. ATTORNEY

24. SIGNATURE OF DISTRICT ATTORNEY

25. SIGNATURE OF COUNTY ATTORNEY

26. SIGNATURE OF TOWNSHIP ATTORNEY

27. SIGNATURE OF VILLAGE ATTORNEY

28. SIGNATURE OF CITY ATTORNEY

29. SIGNATURE OF JUDGE OF THE SUPREME COURT

30. SIGNATURE OF JUDGE OF THE COURTS

31. SIGNATURE OF JUDGE OF THE JUSTICE

32. SIGNATURE OF JUDGE OF THE PEACE

33. SIGNATURE OF JUDGE OF THE COMMON PLEAS

34. SIGNATURE OF JUDGE OF THE CHANCERY

35. SIGNATURE OF JUDGE OF THE EXCHEQUER

36. SIGNATURE OF JUDGE OF THE BENCH

37. SIGNATURE OF JUDGE OF THE BAR

38. SIGNATURE OF JUDGE OF THE ROYAL

39. SIGNATURE OF JUDGE OF THE COMMONS

40. SIGNATURE OF JUDGE OF THE HOUSE OF COMMONS

41. SIGNATURE OF JUDGE OF THE HOUSE OF LORDS

42. SIGNATURE OF JUDGE OF THE HOUSE OF COMMONS

43. SIGNATURE OF JUDGE OF THE HOUSE OF LORDS

44. SIGNATURE OF JUDGE OF THE HOUSE OF COMMONS

45. SIGNATURE OF JUDGE OF THE HOUSE OF LORDS

12867

CERTIFICATE OF DEATH

12825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Prince Georges Maryland			
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Michigan Park Hills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Michigan Park Hills			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5418-15th Place				d. STREET ADDRESS 5418-15th Place			
3. NAME OF DECEASED (Type or print) First Middle Last Palma Gallo				4. DATE OF DEATH 11/24/58 1958			
6. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1897 61 yrs.	
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home				10b. KIND OF BUSINESS OR INDUSTRY Italy		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. FATHER'S NAME Louis Bloise				13. MOTHER'S MAIDEN NAME Rose Kanebia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Theresa De Banno 2204-Corbin Ave. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day - 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10/17, 1957, to 11/24, 1958, that I last saw the deceased alive on 11/12, 1958, and that death occurred at 1:10 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M. Trozzo Jr.				ADDRESS (Street, city or town, state) 1840 Michigan Ave NE			
PHYSICIAN'S NAME (Type) FRANK M. TROZZO				DATE SIGNED 11/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town or county) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Inc.				ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR NOV 26 58	
						24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Handwritten: John Doe]</p>		<p>2. SEX                  [Handwritten: Male]</p>		<p>3. AGE                  [Handwritten: 45]</p>	
<p>4. DATE OF DEATH                  [Handwritten: 10/15/1918]</p>		<p>5. TIME OF DEATH                  [Handwritten: 10:30 AM]</p>		<p>6. PLACE OF DEATH                  [Handwritten: Home]</p>	
<p>7. CAUSE OF DEATH                  [Handwritten: Pneumonia]</p>		<p>8. MANNER OF DEATH                  [Handwritten: Natural]</p>		<p>9. PLACE OF BIRTH                  [Handwritten: Texas]</p>	
<p>10. OCCUPATION                  [Handwritten: Farmer]</p>		<p>11. EDUCATION                  [Handwritten: High School]</p>		<p>12. RELIGION                  [Handwritten: Methodist]</p>	
<p>13. MARITAL STATUS                  [Handwritten: Married]</p>		<p>14. DATE OF MARRIAGE                  [Handwritten: 1910]</p>		<p>15. NAME OF SPOUSE                  [Handwritten: Jane Doe]</p>	
<p>16. NAME OF PHYSICIAN                  [Handwritten: Dr. Smith]</p>		<p>17. NAME OF FUNERAL HOME                  [Handwritten: Johnson &amp; Co.]</p>		<p>18. NAME OF BURIAL PLACE                  [Handwritten: Oak Hill Cemetery]</p>	
<p>19. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>		<p>20. SIGNATURE OF WITNESSES                  [Handwritten: Jane Doe, Dr. Smith]</p>		<p>21. SIGNATURE OF REGISTRAR                  [Handwritten: J. B. Smith]</p>	

THIS CERTIFICATE IS VALID FOR THE STATE OF TEXAS ONLY.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12825

## CERTIFICATE OF DEATH

Reg. Dist. No. 12826

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>524 Main St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Kathy Lynn Garber</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 Nov 1958</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S..A</b>		13. FATHER'S NAME <b>James N Garber</b>		14. MOTHER'S MAIDEN NAME <b>Jean Gibson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>759.3</b>		17. INFORMANT <b>Robert S. McGeney</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anomaly of central nervous system</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>22 Nov.</b> , 19 <b>58</b> , to <b>23 Nov.</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>23 Nov 1958</b> , 19 <b>58</b> , and that death occurred at <b>9:30 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert S. McGeney</b> M.D.				ADDRESS (Street, city or town, state) <b>402 MAIN ST. LAUREL, MD.</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harrison Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hawkins Co. Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. Robert McGeney</b> M.D.				24a. REC'D BY REGISTRAR <b>DEC 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1988

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Race: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Manner of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Address of informant: \_\_\_\_\_

15. Date of completion: \_\_\_\_\_





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12827

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>15415 Quantona St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Leon Gordon</u>		4. DATE OF DEATH <u>Nov 9 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1938</u> 24 yrs.
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTH PLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Max Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Meade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>102-124-121</u>	
17. INFORMANT <u>Mr. Billy Gordon</u>		Address <u>102-124-121</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of base of skull</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto that ran off road and struck a pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 11-9 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Antietam Rd</u>		20f. City or town <u>Antietam</u> (County) <u>P. D.</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 9, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland.</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



NEW STATE  
DEPT.

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*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12868

## CERTIFICATE OF DEATH

Reg. Dist. No. 12828

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AF BASE</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>QBAF HOSPITAL, ANDREWS</u>		d. STREET ADDRESS <u>15846 26th AVENUE S.E.</u>	
3. NAME OF DECEASED (Type or print) First, Middle, Last <u>STEPHEN MARTIN GOSSEN</u>		4. DATE OF DEATH Month, Day, Year <u>NOVEMBER 18 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>NA</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 18, 58</u>
9. AGE (In years lost birthday) yrs. <u>—</u>		10. AGE (In years lost birthday) yrs. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	
11. BIRTHPLACE (State or foreign country) <u>USAF HOSP ANDREWS,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES M GOSSEN</u>		14. MOTHER'S MAIDEN NAME <u>HELEN I. SANDERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u>		16. SOCIAL SECURITY NO. <u>NA</u>	
17. INFORMANT <u>FATHER - JAMES M GOSSEN</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neonatal asoxia</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Abruptio Placentae</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Oct</u> , 19 <u>58</u> , to <u>18 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>18 Oct</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18 NW 58</u> DATE SIGNED <u>18 Oct 58</u>			
ACTUAL SIGNATURE <u>Marvin S. Eiger</u> M.D. <u>USAF Hosp. Andrews</u>			
PHYSICIAN'S NAME (Type) <u>MARVIN S. EIGER, CAPT, USAF(MD) ANDREWS AFBASE, WASH. 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 24 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>NOV 21 '58</u>	
ADDRESS <u>816 H ST. N.E. WASH. 2, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	

2050292xv2

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>		<p>3. AGE                  [Faint text]</p>	
<p>4. DATE OF DEATH                  [Faint text]</p>		<p>5. TIME OF DEATH                  [Faint text]</p>		<p>6. PLACE OF DEATH                  [Faint text]</p>	
<p>7. CAUSE OF DEATH                  [Faint text]</p>		<p>8. MANNER OF DEATH                  [Faint text]</p>		<p>9. MEDICAL HISTORY                  [Faint text]</p>	
<p>10. HISTORY OF PRESENT ILLNESS                  [Faint text]</p>		<p>11. PHYSICAL EXAMINATION                  [Faint text]</p>		<p>12. LABORATORY EXAMINATIONS                  [Faint text]</p>	
<p>13. TREATMENT                  [Faint text]</p>		<p>14. POST-MORTEM EXAMINATION                  [Faint text]</p>		<p>15. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>16. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>17. SIGNATURE OF WITNESSES                  [Faint text]</p>		<p>18. SIGNATURE OF DECEASED                  [Faint text]</p>	

RECEIVED  
 BALTIMORE  
 DEPARTMENT OF HEALTH  
 JAN 10 1910







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12869

## CERTIFICATE OF DEATH

Reg. Dist. No. 12831

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>				c. LENGTH OF STAY IN 1b <b>23 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1222--64th Ave.,</b>				d. STREET ADDRESS <b>1222--64th Ave.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MOLLIE</b> Middle <b>ELLEN</b> Last <b>HALE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3rd,</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16th, 1868</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Mirah Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lee Hale, 534 Lebaum St. S.E. Wash. DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic bronchitis - coronary arteriosclerosis</b> DUE TO (c) <b>10 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While o. m. Not while o. m. at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1953</b> 19____, to <b>Nov 9 1958</b> , that I last saw the deceased alive on <b>Nov. 3 1958</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3404 Cheverly Avenue, Cheverly, Md.</b> DATE SIGNED <b>11/3/1958</b>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.							
PHYSICIAN'S NAME (Type) <b>John Kehoe</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12870

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. STREET ADDRESS 3400 Holmead Pl., N.W. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Magdalene - Harris		4. DATE OF DEATH Month Day Year 11 27 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 12/22/22	9. AGE (In years lost birthday) yrs. 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Mr. Helen Dapkus Bethesda, Md.	11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME Louis McBride		14. MOTHER'S MAIDEN NAME Phyllis Potter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Arteriosclerotic & Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24, 19 58, to 11/27, 19 58, that I last saw the deceased alive on 11/26, 19 58, and that death occurred at 3:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) DATE SIGNED 11/27/58	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale Hospital Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) 46 Berrings Rd. Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Johnson, J. J.		ADDRESS 4804 Ga. Ave. N.W.	
24a. REC'D BY REGISTRAR DEC 30 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE TO

CERTIFICATE OF DEATH

1887

1. NAME OF DECEASED		2. SEX		3. AGE		4. OCCUPATION		5. PLACE OF BIRTH		6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		35		Carpenter		Baltimore, Md.		Jan 15, 1887		10:30 AM		Heart Disease		Baltimore, Md.		J. H. Harris		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER		16. NAME OF CHURCH		17. NAME OF FUNERAL HOME		18. NAME OF UNDERTAKER		19. NAME OF COFFIN		20. NAME OF CASK		21. NAME OF CASK		22. NAME OF CASK		23. NAME OF CASK		24. NAME OF CASK	
Baltimore, Md.		Greenwood Cemetery		J. H. Harris		St. Paul's Church		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. OCCUPATION  
5. PLACE OF BIRTH  
6. DATE OF DEATH  
7. TIME OF DEATH  
8. CAUSE OF DEATH  
9. PLACE OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. PLACE OF INTERMENT  
14. NAME OF CEMETERY  
15. NAME OF MINISTER  
16. NAME OF CHURCH  
17. NAME OF FUNERAL HOME  
18. NAME OF UNDERTAKER  
19. NAME OF COFFIN  
20. NAME OF CASK  
21. NAME OF CASK  
22. NAME OF CASK  
23. NAME OF CASK  
24. NAME OF CASK







may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12828

CERTIFICATE OF DEATH

12834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>P.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN 1b <b>adm. 3-2-58</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 28 D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>				d. STREET ADDRESS <b>5623 Knollwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>H.</b> Last <b>HENRY</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 4-5-1886</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L HARRINGTON</b>				14. MOTHER'S MAIDEN NAME <b>EINA E. NEAL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS LAUREL SANITARIUM</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>apoplexy 334</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>cerebral arteriosclerosis</b> (c) <b>associated with psychotic reaction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <b>1</b> p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1956</b> , to <b>Nov. 2, 1958</b> , that I last saw the deceased alive on <b>Nov. 2, 1958</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Erika P. Kraemer</b>				ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b> DATE SIGNED <b>11-2-58</b>			
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>				<b>LAUREL MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. [illegible]</b>				ADDRESS <b>Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>	
4. DATE OF DEATH <b>1945</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF BIRTH <b>MASSACHUSETTS</b>	
10. DATE OF BIRTH <b>1900</b>		11. TIME OF BIRTH <b>10:30 AM</b>		12. PLACE OF BIRTH <b>MASSACHUSETTS</b>	
13. NAME OF FATHER <b>JOHN J. BROWN</b>		14. NAME OF MOTHER <b>MARY J. BROWN</b>		15. NAME OF SPOUSE <b>MARY J. BROWN</b>	
16. NAME OF CHILDREN <b>JOHN J. BROWN</b>		17. NAME OF CHILDREN <b>MARY J. BROWN</b>		18. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
19. NAME OF CHILDREN <b>MARY J. BROWN</b>		20. NAME OF CHILDREN <b>JOHN J. BROWN</b>		21. NAME OF CHILDREN <b>MARY J. BROWN</b>	
22. NAME OF CHILDREN <b>JOHN J. BROWN</b>		23. NAME OF CHILDREN <b>MARY J. BROWN</b>		24. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
25. NAME OF CHILDREN <b>MARY J. BROWN</b>		26. NAME OF CHILDREN <b>JOHN J. BROWN</b>		27. NAME OF CHILDREN <b>MARY J. BROWN</b>	
28. NAME OF CHILDREN <b>JOHN J. BROWN</b>		29. NAME OF CHILDREN <b>MARY J. BROWN</b>		30. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
31. NAME OF CHILDREN <b>MARY J. BROWN</b>		32. NAME OF CHILDREN <b>JOHN J. BROWN</b>		33. NAME OF CHILDREN <b>MARY J. BROWN</b>	
34. NAME OF CHILDREN <b>JOHN J. BROWN</b>		35. NAME OF CHILDREN <b>MARY J. BROWN</b>		36. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
37. NAME OF CHILDREN <b>MARY J. BROWN</b>		38. NAME OF CHILDREN <b>JOHN J. BROWN</b>		39. NAME OF CHILDREN <b>MARY J. BROWN</b>	
40. NAME OF CHILDREN <b>JOHN J. BROWN</b>		41. NAME OF CHILDREN <b>MARY J. BROWN</b>		42. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
43. NAME OF CHILDREN <b>MARY J. BROWN</b>		44. NAME OF CHILDREN <b>JOHN J. BROWN</b>		45. NAME OF CHILDREN <b>MARY J. BROWN</b>	
46. NAME OF CHILDREN <b>JOHN J. BROWN</b>		47. NAME OF CHILDREN <b>MARY J. BROWN</b>		48. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
49. NAME OF CHILDREN <b>MARY J. BROWN</b>		50. NAME OF CHILDREN <b>JOHN J. BROWN</b>		51. NAME OF CHILDREN <b>MARY J. BROWN</b>	
52. NAME OF CHILDREN <b>JOHN J. BROWN</b>		53. NAME OF CHILDREN <b>MARY J. BROWN</b>		54. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
55. NAME OF CHILDREN <b>MARY J. BROWN</b>		56. NAME OF CHILDREN <b>JOHN J. BROWN</b>		57. NAME OF CHILDREN <b>MARY J. BROWN</b>	
58. NAME OF CHILDREN <b>JOHN J. BROWN</b>		59. NAME OF CHILDREN <b>MARY J. BROWN</b>		60. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
61. NAME OF CHILDREN <b>MARY J. BROWN</b>		62. NAME OF CHILDREN <b>JOHN J. BROWN</b>		63. NAME OF CHILDREN <b>MARY J. BROWN</b>	
64. NAME OF CHILDREN <b>JOHN J. BROWN</b>		65. NAME OF CHILDREN <b>MARY J. BROWN</b>		66. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
67. NAME OF CHILDREN <b>MARY J. BROWN</b>		68. NAME OF CHILDREN <b>JOHN J. BROWN</b>		69. NAME OF CHILDREN <b>MARY J. BROWN</b>	
70. NAME OF CHILDREN <b>JOHN J. BROWN</b>		71. NAME OF CHILDREN <b>MARY J. BROWN</b>		72. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
73. NAME OF CHILDREN <b>MARY J. BROWN</b>		74. NAME OF CHILDREN <b>JOHN J. BROWN</b>		75. NAME OF CHILDREN <b>MARY J. BROWN</b>	
76. NAME OF CHILDREN <b>JOHN J. BROWN</b>		77. NAME OF CHILDREN <b>MARY J. BROWN</b>		78. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
79. NAME OF CHILDREN <b>MARY J. BROWN</b>		80. NAME OF CHILDREN <b>JOHN J. BROWN</b>		81. NAME OF CHILDREN <b>MARY J. BROWN</b>	
82. NAME OF CHILDREN <b>JOHN J. BROWN</b>		83. NAME OF CHILDREN <b>MARY J. BROWN</b>		84. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
85. NAME OF CHILDREN <b>MARY J. BROWN</b>		86. NAME OF CHILDREN <b>JOHN J. BROWN</b>		87. NAME OF CHILDREN <b>MARY J. BROWN</b>	
88. NAME OF CHILDREN <b>JOHN J. BROWN</b>		89. NAME OF CHILDREN <b>MARY J. BROWN</b>		90. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
91. NAME OF CHILDREN <b>MARY J. BROWN</b>		92. NAME OF CHILDREN <b>JOHN J. BROWN</b>		93. NAME OF CHILDREN <b>MARY J. BROWN</b>	
94. NAME OF CHILDREN <b>JOHN J. BROWN</b>		95. NAME OF CHILDREN <b>MARY J. BROWN</b>		96. NAME OF CHILDREN <b>JOHN J. BROWN</b>	
97. NAME OF CHILDREN <b>MARY J. BROWN</b>		98. NAME OF CHILDREN <b>JOHN J. BROWN</b>		99. NAME OF CHILDREN <b>MARY J. BROWN</b>	
100. NAME OF CHILDREN <b>JOHN J. BROWN</b>		101. NAME OF CHILDREN <b>MARY J. BROWN</b>		102. NAME OF CHILDREN <b>JOHN J. BROWN</b>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12829 CERTIFICATE OF DEATH

12835

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> <span style="float: right;">15X-2</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>Hild</u> Last <u>Hild</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>11</u> Year <u>19 58</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>5/18/83</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Meat Supply</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Meat</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hungary</u>							
<b>13. FATHER'S NAME</b> <u>John Hild</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Not Available</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Frances Hild</u> Address <u>address same</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> DUE TO (b) <u>uremia</u> DUE TO (c) <u>Cardio Vascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy Benign</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that I attended the deceased from</b> <u>10/21/58</u> , 19__, <b>to</b> <u>11/14/58</u> , 19__, <b>that I last saw the deceased alive on</b> <u>11/14/58</u> , 19__ <b>and that death occurred at</b> <u>12:50AM</u> , <b>from the causes and on the date stated above.</b>											
<b>ACTUAL SIGNATURE</b> <u>Louis B. Bachrach MD</u>		<b>ADDRESS</b> (Street, city or town, state) <u>915-19 St. N. W. Washington D. C.</u>		<b>DATE SIGNED</b> <u>11/14/58</u>							
<b>PHYSICIAN'S NAME (Type)</b> <u>LOUIS B. BACHRACH M.D.</u>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Nov. 17, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Union Cemetery</u>							
<b>22d. LOCATION</b> (City, town, or county) <u>Burtonsville</u> <span style="float: right;">(State) <u>Maryland</u></span>		<b>24a. REC'D BY REGISTRAR</b> <u>Nov 17 '58</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Carroll St NW DC</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner: *W. L. Etienne*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Items 8,9 Film G235 11-13-58 et										
12871 CERTIFICATE OF DEATH 12836										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md			c. LENGTH OF STAY IN 1b 39 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Berwyn Heights, Md.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8609 57th avenue					d. STREET ADDRESS 8609 57th avenue, ..			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mortimer C. Johnstone					4. DATE OF DEATH Month Day Year Nov 2, 1958					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 14, 1887		9. AGE (In years last birthday) 70 1/2 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pressman		10b. KIND OF BUSINESS OR INDUSTRY newspaper		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Robert B Johnstone					14. MOTHER'S MAIDEN NAME Mary E Graft					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Lillian A Johnstone Berwyn Heights, Md;						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio-sclerotic cardio-vascular disease DUE TO (c) Vascular disease INTERVAL BETWEEN ONSET AND DEATH 44 + 10 yr +										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 30, 1958, to Nov 2, 1958, that I last saw the deceased alive on Oct 30, 1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4713 Berwyn Rd DATE SIGNED 11-3-58 W. L. ETIENNE College Park, Md										
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Nov 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory			22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE Anthony L. Hume	

W. L. STEWART

W. L. STEWART

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1927

1927

Name of Deceased		W. L. STEWART	
Date of Death		Nov 19 1927	
Place of Death		Home	
Age		40	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Tuberculosis	
Duration of Illness		6 months	
Place of Burial		Catholic Cemetery	
Date of Burial		Nov 22 1927	
Signature of Physician		J. H. [illegible]	
Signature of Registrar		[illegible]	
Signature of Coroner		[illegible]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly D.O.G.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen Hosp		d. STREET ADDRESS 642-L Street N.W.	
3. NAME OF DECEASED (Type or print) Cleveland Jones		4. DATE OF DEATH Nov-6-1958	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-94
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY R-R-	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Jones		14. MOTHER'S MAIDEN NAME Love Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give kind or dates of service) Yes W.W.I.		16. SOCIAL SECURITY NO. 253-20-0745	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute congestive heart failure (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
24b. REGISTRAR'S SIGNATURE			

Mr. McEntire 412 N. St. N.E.

Washington D.C.

DATE NOV 10 '58

Charles S. Kraus



NEW STATE  
HEALTH DEPT.

STATE OF ALABAMA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]*

Attest: \_\_\_\_\_  
Medical Examiner

Witness: \_\_\_\_\_  
County Clerk

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public for the State of Alabama

Period: 11/12/20  
Alleged Cause of Death: \_\_\_\_\_

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>Head on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mr. Robyns Office</u>			e. STREET ADDRESS <u>RFD #2, Box 70 Waldorf Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Delinda Ann Jones</u>			4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1958</u>		9. AGE (in years last birthday) yrs. <u>7</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			13. FATHER'S NAME <u>Harry Bernard Jones</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Elmer Munson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Harry B Jones, Same as #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Piscataway, Md</u>	(County) <u>Prince George's</u>	(State) <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov 9, 1958</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) <u>Piscataway, Md</u>	(State) <u>Md</u>	
23. GENERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Ballis</u>		ADDRESS <u>4339 Huntol, N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

2077339XVI

18872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
HAYLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]*

NAME OF DECEASED	DATE OF DEATH
SEX	AGE
CAUSE OF DEATH	PLACE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL
NAME OF FUNERAL HOME	NAME OF MINISTER

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12873 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D.C.</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gardiner Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bob</b> First <b>Lee</b> Middle <b>King</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1940</b>
9. AGE (In years last birthday) <b>18</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oscar R. King</b>		14. MOTHER'S MAIDEN NAME <b>Emma Pruett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Emma King (Mother)</b> Address <b>Salem Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>823X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of the base of the skull, Crushed chest</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an auto that ran off the road, struck fixed object</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:20 PM</b> a. m. <b>11/10/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Gardiner Road</b>		20f. (City or town) (County) (State) <b>Accokeek P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 11, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salem Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 14 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kline</b>	

MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Time of Death		Manner of Death		Signature of Examiner	
Residence of Deceased		Occupation		Signature of Physician	
Date of Birth		Place of Birth		Signature of Coroner	
Time of Birth		Manner of Birth		Signature of Registrar	
Residence of Birth		Occupation of Birth		Signature of Burial Officer	
Date of Burial		Place of Burial		Signature of Minister	
Time of Burial		Manner of Burial		Signature of Undertaker	
Residence of Burial		Occupation of Burial		Signature of Funeral Home	
Date of Funeral		Place of Funeral		Signature of Family	
Time of Funeral		Manner of Funeral		Signature of Friends	
Residence of Funeral		Occupation of Funeral		Signature of Community	
Date of Interment		Place of Interment		Signature of Cemetery	
Time of Interment		Manner of Interment		Signature of Graveyard	
Residence of Interment		Occupation of Interment		Signature of Burial Society	
Date of Reburial		Place of Reburial		Signature of Reburial Officer	
Time of Reburial		Manner of Reburial		Signature of Reburial Society	
Residence of Reburial		Occupation of Reburial		Signature of Reburial Officer	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12840

12831

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Dale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>Northern Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Robert J. Rivett Jr</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-33</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. Rivett</u>		14. MOTHER'S MAIDEN NAME <u>Frances Elizabeth Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1954-57</u>		16. SOCIAL SECURITY NO. <u>214-30-2143</u>	
17. INFORMANT <u>Donna Jean Rivett - Same address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>operator in automobile in collision with a tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> a.m. <u>11-10-1958</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Rivindale - Pr. Geo - Md.</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		DATE SIGNED <u>11-10-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 14, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Gasch's Sons</u>		24. REC'D BY REGISTRAR <u>NOV 14 '58</u>	
ADDRESS <u>Hyattsville Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1921

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15, 1921</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>	
<p>PREVIOUS ILLNESS <i>None</i></p>		<p>PREVIOUS SURGERY <i>None</i></p>		<p>PREVIOUS TRAUMA <i>None</i></p>		<p>PREVIOUS DRUGS <i>None</i></p>	
<p>POST-MORTEM EXAMINATION <i>Not performed</i></p>		<p>TO BE FILLED BY THE MEDICAL EXAMINER</p>		<p>TO BE FILLED BY THE MEDICAL EXAMINER</p>		<p>TO BE FILLED BY THE MEDICAL EXAMINER</p>	
<p>SIGNATURE OF MEDICAL EXAMINER <i>Wm. H. Smith</i></p>		<p>DATE <i>Jan 15, 1921</i></p>		<p>PLACE <i>Baltimore, Md.</i></p>		<p>TO BE FILLED BY THE MEDICAL EXAMINER</p>	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr-Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mount Rainier</u>	
c. LENGTH OF STAY IN 1b <u>2009</u>		d. STREET ADDRESS <u>13814 - 31st St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harriet Kleindienst</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1880</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hebrin</u>		14. MOTHER'S MARDEN NAME <u>Patsy Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01254</u>	
17. INFORMANT <u>Frank Kleindienst</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Maloney</u>		DATE SIGNED <u>11-15-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malloy's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>3200-R.I. Ave.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>
ADDRESS <u>Mt. Rainier, Md.</u>		DATE <u>NOV 19 '58</u>	


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Nov. 10, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>WINONA</i>	22d. LOCATION (City, town, or county) <i>WINONA MINNESOTA</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>RINALDI</i>		ADDRESS <i>WASH., DC. FUNERAL HOME 816 HST. N.E.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12875

## CERTIFICATE OF DEATH

Reg. Dist. No. 12843

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Lanell)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Lanell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Rennie A. Lammers</u>		4. DATE OF DEATH <u>November 6 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkridge, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Otten</u>		14. MOTHER'S MAIDEN NAME <u>Mary Simon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT <u>Mrs Margaret Manning Lanell Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>4</u> hrs. (c) <u>Old Age</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9040</u> <u>Prostatic Pits 8/30/58</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out home</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10</u> <u>8/30</u> 19 <u>58</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Lanell P.G. Md</u> (County) (State)
21. I certify that I attended the deceased from <u>8/30</u> , 19 <u>58</u> , to <u>11/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>58</u> , and that death occurred at <u>1250</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u>		ADDRESS (Street, city or town, state) <u>Lanell Md</u> DATE SIGNED <u>11/6/58</u>	
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>	22d. LOCATION (City, town, or county) <u>Lanell Maryland</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Canadian</u>		24a. REC'D BY REGISTRAR <u>Nov 13 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraske</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1937

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. DATE OF DEATH                  _____</p>		<p>5. TIME OF DEATH                  _____</p>		<p>6. PLACE OF DEATH                  _____</p>	
<p>7. CAUSE OF DEATH                  _____</p>		<p>8. MANNER OF DEATH                  _____</p>		<p>9. PLACE OF BIRTH                  _____</p>	
<p>10. OCCUPATION                  _____</p>		<p>11. EDUCATION                  _____</p>		<p>12. RELIGION                  _____</p>	
<p>13. MARITAL STATUS                  _____</p>		<p>14. DATE OF MARRIAGE                  _____</p>		<p>15. NAME OF SPOUSE                  _____</p>	
<p>16. NAME OF PHYSICIAN                  _____</p>		<p>17. NAME OF NURSE                  _____</p>		<p>18. NAME OF MINISTER                  _____</p>	
<p>19. NAME OF FUNERAL HOME                  _____</p>		<p>20. NAME OF BURIAL PLACE                  _____</p>		<p>21. NAME OF CEMETERY                  _____</p>	
<p>22. NAME OF INTERVIEWER                  _____</p>		<p>23. NAME OF WITNESS                  _____</p>		<p>24. NAME OF SIGNER                  _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12876

CERTIFICATE OF DEATH

Reg. Dist. No. 12844

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN TB <u>32 yrs.</u>		d. STREET ADDRESS <u>Route 2 - Box 152</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE</u> First <u>E.</u> Middle <u>FAVIER</u> Last		4. DATE OF DEATH <u>Nov. 18 1958</u> Month <u>Nov.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10 - 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WAITER MARR</u>		14. MOTHER'S MAIDEN NAME <u>Virginia MARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia H. Frye</u> Address <u>Route 2 - Box 152 Clinton MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 mo.</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15 1958</u> to <u>Nov 18, 1958</u> , that I last saw the deceased alive on <u>March 17, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5480 Silver Hill Rd SE Washington DC</u>			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.			
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN NATTA</u>		<u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>	22d. LOCATION (City, town, or county) (State) <u>Landland MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661-Goth Hope Rd SE WASH DC</u>		24a. REG'D BY REGISTRAR <u>NOV 20 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

12833  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 1/2 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale</b>	
d. STREET ADDRESS <b>5321 Taylor St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W</b> Last <b>Laughlin</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1890</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. FIREMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>WINONA, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES LAUGHLIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA LAUGHLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>(WIFE)</b>	
17. INFORMANT <b>MRS. CECELIA M. LAUGHLIN</b>		Address <b>RIVERDALE, MD.</b> <b>5321-TAYLOR ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immature aortic aneurysm of the left coronary artery.</b> (c) <b>Arteriosclerosis of the heart disease?</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 16, 1958</b> , to <b>November 16, 1958</b> , that I last saw the deceased alive on <b>November 16, 1958</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1816 "R" NW, Wash DC</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Jeanne C Bateman</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Jeanne C Bateman</b>		Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 18, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>	
ADDRESS <b>1300-N 34th NW WASH DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

CERTIFICATE OF DEATH

11-33

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

## CERTIFICATE OF DEATH

Reg. Dist. No.

12846

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		d. STREET ADDRESS <u>939 R. I. Ave., N. W.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>H</u> Last <u>LEWIS</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>21</u> Year <u>1958</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/23/1900</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Spotter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Needles Dry Cleaners</u>	<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John H. Lewis</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Williams</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) <u>-</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578-18-3560</u>	<b>17. INFORMANT</b> <u>Decedent</u>
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis, far advanced</u> DUE TO (c) <u>-</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>15 minutes</u> <u>4 yrs., 6 mos.</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>260X Diabetes mellitus</u>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>11/7</u> , 19 <u>58</u> , <b>to</b> <u>11/21</u> , 19 <u>58</u> , <b>that I last saw the deceased alive on</b> <u>11/20</u> , 19 <u>58</u> , <b>and that death occurred at</b> <u>2:15 A.M.</u> , <b>from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <u>Moe Weiss</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Glenn Dale Hospital</u> <b>DATE SIGNED</b> <u>11/21/58</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Moe Weiss, M. D.</u>		<u>Glenn Dale, Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>11/25/58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Wash. D.C.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Johnson &amp; Jenkins</u>		<b>ADDRESS</b> <u>4804 Benga Ave. N.W.</u>	<b>24a. REC'D BY REGISTRAR</b> <u>DATE NOV 26 '58</u>
		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12878

## CERTIFICATE OF DEATH

Reg. Dist. No. 12847

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1234 Pleasant Street, S.E.	
3. NAME OF DECEASED (Type or print) First John Middle S. Last Livesay		4. DATE OF DEATH Month 11 Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/20/01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City Hospital	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Joseph Livesay		14. MOTHER'S MAIDEN NAME Hedda Ann Tench	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 224-05-0823	17. INFORMANT Decedent
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right lung, etiology undetermined 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/19, 1958, to 11/22, 1958, that I last saw the deceased alive on 11/22, 1958, and that death occurred at 1:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 11/22/58 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-25-58	22c. NAME OF CEMETERY OR CREMATORY Congressional	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi		ADDRESS 816 H St. N.E.	24a. REC'D BY REGISTRAR DATE NOV 26 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>AVONDALE</u>				c. LENGTH OF STAY IN TB <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>M.</u> Last <u>MAHANEY</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>19</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-11</u> 46 <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEREMIAH MAHANEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY SHEEHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-2038</u>		17. INFORMANT Address <u>Avondale Ind.</u> <u>Mrs Mary Mahaney 2012 Hayden Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Probably Carcinoma Right Breast</u> DUE TO (c) <u>(This was cured by radical mastectomy)</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>7 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>NOV.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 8, 1958</u> , to <u>Nov. 19, 1958</u> , that I last saw the deceased alive on <u>Nov. 18, 1958</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. van Kinsbergen</u> M.D.				ADDRESS (Street, city or town, state) <u>29 GRANT CIR., NW, Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>M. VAN KINSBERGEN</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u> ADDRESS <u>3821-14th St NW, Wash. D.C.</u>				24. REC'D BY REGISTRAR <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Haines</u>	



# CERTIFICATE OF DEATH

STATE OF NEW YORK

1910

FILE NO.

DATE

TIME

PLACE

AGE

SEX

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

RESIDENCE

DECEASED

REPORTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12880  
CERTIFICATE OF DEATH

12849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 2 mos., &amp; 17 days</u>				d. STREET ADDRESS <u>55 S. St., N. W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alton</u> Middle <u>-</u> Last <u>Marable</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. E. Cramer Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. E. Cramer Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Antwine Marable</u>				14. MOTHER'S MAIDEN NAME <u>Siller Berg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-12-6401</u>		17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral, etiology undetermined</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopleural fistula, right lung</u> DUE TO (c) <u>Right upper lobectomy/segment of right lower lobe for tuberculosis, 11/7/58</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Glenn Dale, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>9/6/57, 19--</u> , to <u>11/23</u> , 1958, that I last saw the deceased alive on <u>11/23</u> , 1958, and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> 11/23/58				DATE SIGNED <u>11/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/24/58</u>		22b. DATE HEREOF <u>11/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Muirkirk, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines &amp; Co.</u> ADDRESS <u>3015-12th St. N.E.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

# CERTIFICATE OF DEATH

1900

STATE OF NEW YORK - ALBANY

1900

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1855		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOW		DIVORCED		RE-MARRIED		OTHER		REMARKS	
JAMES H. HARRIS		JANE H. HARRIS		M		W		1855		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CAUSE OF DEATH		MEDICAL ATTENDANT		NATURAL		ARTIFICIAL	
1900		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HEART DISEASE		DR. J. H. HARRIS		NATURAL		ARTIFICIAL	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CLERK		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF DEPUTY	
JAMES H. HARRIS		JANE H. HARRIS		DR. J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED  
JAN 10 1901  
ALBANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

## CERTIFICATE OF DEATH

Reg. Dist. No.

12850

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DIST. OF COLUMBIA</u> b. COUNTY <u>COLUMBIA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN DALE</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 MOS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 478-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENN DALE HOSP.</u>		d. STREET ADDRESS <u>242 15TH ST S.E.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>L.</u> Last <u>McCOLLUM</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/09</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR SUPPLY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N. CAROLINA</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.</u>
13. FATHER'S NAME <u>WILL McCOLLUM</u>		14. MOTHER'S MAIDEN NAME <u>LUCY BOYDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>239-14-4081</u>	17. INFORMANT <u>DECEASED</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT. LUNG BRONCHOGENIC CARCINOMA</u> <u>162.1</u> DUE TO <u>METASTASIS TO RT. PLEURA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>DOORX</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULM. TUBERCULOSIS ACTIVE, EXTENT UNDET.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/22</u> , 19 <u>58</u> , to <u>11/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/1</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>MOE WEISS</u>		ADDRESS (Street, city or town, state) <u>GLENN DALE HOSP.</u> DATE SIGNED <u>11/5/58</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS M.D.</u>		<u>GLENN DALE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>---</u>	22d. LOCATION (City, town, or county) (State) <u>Winston Salem, N. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Funeral Home 30 H St NE Wash DC</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>

100



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12834

## CERTIFICATE OF DEATH

Reg. Dist. No. 12851

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>J</b> Last <b>Mealy</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18 1901</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Bank accounting office U.S. Govt Wash, D.C.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Michael J Mealy</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Reidy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>_____</b>			
17. INFORMANT <b>Katherine Mealy</b>				Address <b>_____</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>157x</b> (b) <b>Carcinoma of the body and tail of the pancreas</b> DUE TO (c) <b>_____</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>6 months</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1st</b> , 19 <b>58</b> , to <b>Nov 9th</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 9th</b> , 19 <b>58</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Till Bergman</b>				ADDRESS (Street, city or town, state) <b>4314 S. GOLF ST. HYATTSVILLE</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Till Bergman</b>				DATE SIGNED <b>M. O.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Rd N.E. Wash D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				ADDRESS <b>5801 Cleveland Ave Riverdale Md</b>			
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Smith</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1934

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Usual residence</p>		<p>7. Date of death</p>		<p>8. Time of death</p>	
<p>9. Cause of death</p>		<p>10. Manner of death</p>		<p>11. Signature of physician</p>		<p>12. Signature of registrar</p>	
<p>13. Signature of informant</p>		<p>14. Signature of witness</p>		<p>15. Signature of registrar</p>		<p>16. Signature of registrar</p>	
<p>17. Signature of registrar</p>		<p>18. Signature of registrar</p>		<p>19. Signature of registrar</p>		<p>20. Signature of registrar</p>	
<p>21. Signature of registrar</p>		<p>22. Signature of registrar</p>		<p>23. Signature of registrar</p>		<p>24. Signature of registrar</p>	
<p>25. Signature of registrar</p>		<p>26. Signature of registrar</p>		<p>27. Signature of registrar</p>		<p>28. Signature of registrar</p>	
<p>29. Signature of registrar</p>		<p>30. Signature of registrar</p>		<p>31. Signature of registrar</p>		<p>32. Signature of registrar</p>	
<p>33. Signature of registrar</p>		<p>34. Signature of registrar</p>		<p>35. Signature of registrar</p>		<p>36. Signature of registrar</p>	
<p>37. Signature of registrar</p>		<p>38. Signature of registrar</p>		<p>39. Signature of registrar</p>		<p>40. Signature of registrar</p>	
<p>41. Signature of registrar</p>		<p>42. Signature of registrar</p>		<p>43. Signature of registrar</p>		<p>44. Signature of registrar</p>	
<p>45. Signature of registrar</p>		<p>46. Signature of registrar</p>		<p>47. Signature of registrar</p>		<p>48. Signature of registrar</p>	
<p>49. Signature of registrar</p>		<p>50. Signature of registrar</p>		<p>51. Signature of registrar</p>		<p>52. Signature of registrar</p>	
<p>53. Signature of registrar</p>		<p>54. Signature of registrar</p>		<p>55. Signature of registrar</p>		<p>56. Signature of registrar</p>	
<p>57. Signature of registrar</p>		<p>58. Signature of registrar</p>		<p>59. Signature of registrar</p>		<p>60. Signature of registrar</p>	
<p>61. Signature of registrar</p>		<p>62. Signature of registrar</p>		<p>63. Signature of registrar</p>		<p>64. Signature of registrar</p>	
<p>65. Signature of registrar</p>		<p>66. Signature of registrar</p>		<p>67. Signature of registrar</p>		<p>68. Signature of registrar</p>	
<p>69. Signature of registrar</p>		<p>70. Signature of registrar</p>		<p>71. Signature of registrar</p>		<p>72. Signature of registrar</p>	
<p>73. Signature of registrar</p>		<p>74. Signature of registrar</p>		<p>75. Signature of registrar</p>		<p>76. Signature of registrar</p>	
<p>77. Signature of registrar</p>		<p>78. Signature of registrar</p>		<p>79. Signature of registrar</p>		<p>80. Signature of registrar</p>	
<p>81. Signature of registrar</p>		<p>82. Signature of registrar</p>		<p>83. Signature of registrar</p>		<p>84. Signature of registrar</p>	
<p>85. Signature of registrar</p>		<p>86. Signature of registrar</p>		<p>87. Signature of registrar</p>		<p>88. Signature of registrar</p>	
<p>89. Signature of registrar</p>		<p>90. Signature of registrar</p>		<p>91. Signature of registrar</p>		<p>92. Signature of registrar</p>	
<p>93. Signature of registrar</p>		<p>94. Signature of registrar</p>		<p>95. Signature of registrar</p>		<p>96. Signature of registrar</p>	
<p>97. Signature of registrar</p>		<p>98. Signature of registrar</p>		<p>99. Signature of registrar</p>		<p>100. Signature of registrar</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 15

12852

12882

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Run Cove</b> c. LENGTH OF STAY IN 1b <b>49X-3</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Govt. leased waters off Oxon Run Cove</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Ocilla</b> d. STREET ADDRESS <b>Route #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Warren Levi MERRITT</b>				4. DATE OF DEATH Month Day Year <b>November 5 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-13-32</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Warren Henry MERRITT</b>				14. MOTHER'S MAIDEN NAME <b>Anna Lucille (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>				16. SOCIAL SECURITY NO. <b>259-44-2887</b>		17. INFORMANT <b>Official Navy Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Drowning</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While making routine training dive, failed to surface</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>9:15 11 5 58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac River</b>		20f. (City or town) (County) (State) <b>Oxon Run Cove Pr. George Md.</b>	
21. I certify that I attended the deceased from <b>November 5, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>10:27 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Deep Sea Diving School 11-5-58</b>							
ACTUAL SIGNATURE <i>Paul G. Linaweaver</i> PHYSICIAN'S NAME (Type) <b>Paul G. LINAWEAVER, LT, MC, USN</b>				M.D. <b>Deep Sea Diving School</b>			
22a. RURAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>				ADDRESS <b>Adams Funeral Home, 4748 Wisc. Ave., NW, Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>				24c. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Prince George Co. Deputy Medical Examiner notified and remains released to Coroner, District of Columbia, who released remains to U. S. Naval Hospital, Bethesda, Md. for autopsy and disposition. Montgomery Co. Med. Exam. notified

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12835

## CERTIFICATE OF DEATH

Reg. Dist. No. 12853

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>13X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>Seagoville Rd Star Rt. Box 517</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Merson</u> Last <u>Merson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Washington Merson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Dustin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarct</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiac failure and</u> DUE TO (c) <u>disseminated embolisms</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October 17, 1958</u> , to <u>November 7, 1958</u> , that I last saw the deceased alive on <u>November 7, 1958</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Idolo Piernadrei</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Idolo Piernadrei, M.D. 305 Prince George Street, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/10/58</u>		<u>St. Paul Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witt Donaldson</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Nov 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12854

12836

FOR STATE  
HEALTH DEPT.

M

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. STREET ADDRESS <b>11707 Ash Road</b>	
3. NAME OF DECEASED (Type or print) <b>Uldine Evelyn Meyer</b>		4. DATE OF DEATH <b>November 26 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-1925</b>
9. AGE (In years last birthday) <b>33 yrs.</b>		10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
11. BIRTHPLACE (State or foreign country) <b>S, Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Vincent Oliver</b>		14. MOTHER'S MAIDEN NAME <b>Cleo Morrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Norman L. Meyer; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fractured skull and legs</b> (a), stating the underlying cause last. DUE TO (c) <b>Automobile accident</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with another automobile.</b>	
20c. TIME OF INJURY Month, Day, Year <b>8.50 p.m. Nov. 24, 19 58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Rt. 1</b>		20f. (City or town) (County) (State) <b>Muirkirk Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 26, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 29, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Florence South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
NEW YORK

12886

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Johnson		Male		45	
Date of Death		Place of Death		Cause of Death	
November 10, 1955		New York City		Myocardial Infarction	
Time of Death		Physician		Manner of Death	
10:30 AM		Dr. J. H. Smith		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Remarks	
November 10, 1955		New York City		[Blank]	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12855

12837

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>			
c. LENGTH OF STAY IN b. <b>7 days</b>				d. STREET ADDRESS <b>6402 E. Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>M</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 7<sup>TH</sup> 1898</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>20</b> Hours <b>19</b> Min. <b>58</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. GRACE V POORE</b> Address <b>6552 Ritchie Rd Wash. 28 Dc</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastases.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 4</b> , 19 <b>52</b> , to <b>Nov. 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov. 20</b> , 19 <b>58</b> , and that death occurred at <b>5:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6144 Central Ave</b> DATE SIGNED <b>11/20/58</b>							
ACTUAL SIGNATURE <b>William Brainin</b> M.D.				PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Southland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b> ADDRESS <b>517 11<sup>th</sup> St SE</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Hines</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12856

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gardiner Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
3. NAME OF DECEASED (Type or print) <b>Robert Bruce Minnix</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Aug. 1937</b>
9. AGE (In years and birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	11. IF UNDER 24 HRS. Hours <b>11</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Clifton Minnix</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Gillespie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Mary Minnix (Mother)</b> Address <b>Salem, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed skull and chest</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an automobile that ran off road, struck fixed object</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:20</b> o. m. <b>PM 11/10/58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Gardiner Road</b>	20f. (City or town) (County) (State) <b>Accokeek P. G. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>November 11, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salem Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film G236, items 9.11.13 & 14, reg 12/2/58

12838

CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Seabrook</u>	
c. LENGTH OF STAY IN TB <u>4 days</u>		d. STREET ADDRESS <u>9434 DuBarry Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lehman</u> Middle <u>Norman</u> Last <u>Norman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-80</u>
9. AGE (In years lost birthday) <u>78/10</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Production</u>	
11. BIRTHPLACE (State or foreign country) <u>Plymouth, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Aquilla Norman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cobb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Marie B. Wife Address Same</u>	
17. INFORMANT <u>Marie B. Wife Address Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myo Cardiac infarctus</u> DUE TO <u>Arterio sclerotic H &amp; A</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.0</u> DUE TO (c) <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22</u> , 19 <u>58</u> , to <u>11/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 26</u> , 19 <u>58</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>4410 74th Ave</u>		DATE SIGNED <u>11/27/58</u>	
PHYSICIAN'S NAME (Type) <u>F. E. HUSSEY, M.D.</u>		<u>Landon Hills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/29/58</u>		22b. DATE THEREOF <u>Woodlawn</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>COOK FUNERAL HOME BALTO. MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>	
ADDRESS <u>COOK FUNERAL HOME BALTO. MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



12884

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Prince Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Laurel)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Laurel)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry Lee Owens</i>		4. DATE OF DEATH Month Day Year <i>November 15 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 9 1900</i>
9. AGE (In years lost birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Owens</i>		14. MOTHER'S MAIDEN NAME <i>Leahy Tucker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>not</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Wm Owens, Laurel Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma Mouth + Neck</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/1</i> 19 <i>54</i> to <i>11/15/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/15/58</i> , 19 <i>58</i> , and that death occurred at <i>5A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>11/17/58</i>			
ACTUAL SIGNATURE <i>J. M. Warren M.D.</i>		PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 17, 1958</i>		22b. DATE THEREOF <i>Nov 17, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ing Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Laurel Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Connelley</i>		ADDRESS <i>Laurel Md</i>	
24a. REC'D BY REGISTRAR <i>NOV 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12885

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. & D.C. b. COUNTY Pr. Geo's & D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry First Middle Last				4. DATE OF DEATH Nov 28 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1896	
9. AGE (In years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.		11. BIRTHPLACE (State or foreign country) Japan	
13. FATHER'S NAME Henry Deane Page				14. MOTHER'S MAIDEN NAME Sarah Gregg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Dorothy Clark Page Mitchellville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 10 min				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 28, 1958, to Nov 28, 1958, that I last saw the deceased alive on Nov 28, 1958, and that death occurred at 10:40 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Sasser				DATE SIGNED 18 Nov 58			
PHYSICIAN'S NAME (Type) R. B. Sasser, M.D.				Upper Marlboro, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Epis. Cem.		22d. LOCATION (City, town, or county) (State) Collington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12860

1  
FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN lb <u>23 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospiatl</u>				d. STREET ADDRESS <u>1 3714 Jefferson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jennie Vance Patton</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, '75</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Vance</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Stoner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth Bradford; same address as # 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of vomitus</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure due to shock</u> DUE TO (c) <u>Fracture of neck of femur</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>  <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home</u>					
20c. TIME OF INJURY Month, Day, Year <u>11-30</u> a. m. <u>11-25-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-26-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beallsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12861

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyattsville Convalescent Home</b>		e. STREET ADDRESS <b>3423 39th Place</b>	
3. NAME OF DECEASED (Type or print) <b>Amelia Pedone</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-70</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
13. FATHER'S NAME <b>John (Pedone) OYERHOLZER</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>John Pedone; 4311 Lawrence St., Colmar Manor</b>	
17. INFORMANT <b>Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardiovascular disease.</b> (c), stating the underlying cause lost. DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John J. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-5-58</b>		22b. DATE THEREOF <b>11-5-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lernard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>5305 Harbor</b>	
24b. REGISTRAR'S SIGNATURE <b>DATE NOV 5 '58</b>		24c. REGISTRAR'S SIGNATURE <b>DATE NOV 5 '58</b>	

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE  
DEPARTMENT OF HEALTH

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>4620 R. Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Margaret Elizabeth Petrie</b>			4. DATE OF DEATH <b>November 4 19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1897</b>		9. AGE (in years last birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles M. Shaw</b>			14. MOTHER'S MAIDEN NAME <b>Alberta Byer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Petrie; same address as # 2.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary atherosclerosis</b> (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>November 5, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 7, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington Va</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>			24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF NEW YORK  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12841 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>5707 Oaks Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Junior Petty</u>	4. DATE OF DEATH <u>Nov-23</u> 19 <u>58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-13</u>
9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book binder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Agricul.</u>	11. BIRTHPLACE (State or foreign country) <u>District of Col.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Theodore Petty</u>	14. MOTHER'S MAIDEN NAME <u>Malinda Jackson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Walter J. Petty - Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiomegaly renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adhesive pericarditis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>John J. Maloney, M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-23-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Finney</u> ADDRESS <u>30 H Street, N.E.</u>		24a. REC'D BY REGISTRAR <u>NOV 25 58</u>	24b. REGISTRAR'S SIGNATURE <u>William J. Maloney</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12841

STATE OF  
MASSACHUSETTS

WILLIAM BROWN

AGE 45

SEX

DATE

TIME

PLACE

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

POLITICAL

SOCIAL

ETHNIC

LANGUAGES

SKILLS

HOBBIES

SPORTS

TRAVEL

DIET

SMOKING

ALCOHOL

DRUGS

ALLERGIES

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SMOKING

ALCOHOL

DRUGS

ALLERGIES

CHRONIC

ACUTE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

12842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapell Hill</b>	
d. STREET ADDRESS <b>9014 Old Fort Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Plummer</b> Last <b>Plummer</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1882</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Butler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Josephine Shorter</b> Address <b>N. E. 1227 Florida Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>331x</b> DUE TO (c) <b>331x</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 19</b> , 19 <b>58</b> , to <b>Nov 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 22</b> , 19 <b>58</b> , and that death occurred at <b>9:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry N. Carlton</b>		DATE SIGNED <b>11/22/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Harry N. Carlton</b>		ADDRESS (Street, city or town, state) <b>1816 R St. N.W. Wash DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhinert Co. Washington DC</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
ADDRESS <b>3015-12th St NE</b>		DATE <b>NOV 28 '58</b>	

# CERTIFICATE OF DEATH

WILLIAM BOND

<p>1. Name of deceased: WILLIAM BOND</p>	
<p>2. Date of death: [ ]</p>	
<p>3. Place of death: [ ]</p>	
<p>4. Cause of death: [ ]</p>	
<p>5. Signature of physician: [ ]</p>	
<p>6. Signature of registrar: [ ]</p>	
<p>7. Date of registration: [ ]</p>	
<p>8. Place of registration: [ ]</p>	
<p>9. Name of registrar: [ ]</p>	
<p>10. Name of witness: [ ]</p>	
<p>11. Name of witness: [ ]</p>	
<p>12. Name of witness: [ ]</p>	
<p>13. Name of witness: [ ]</p>	
<p>14. Name of witness: [ ]</p>	
<p>15. Name of witness: [ ]</p>	
<p>16. Name of witness: [ ]</p>	
<p>17. Name of witness: [ ]</p>	
<p>18. Name of witness: [ ]</p>	
<p>19. Name of witness: [ ]</p>	
<p>20. Name of witness: [ ]</p>	
<p>21. Name of witness: [ ]</p>	
<p>22. Name of witness: [ ]</p>	
<p>23. Name of witness: [ ]</p>	
<p>24. Name of witness: [ ]</p>	
<p>25. Name of witness: [ ]</p>	
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<p>91. Name of witness: [ ]</p>	
<p>92. Name of witness: [ ]</p>	
<p>93. Name of witness: [ ]</p>	
<p>94. Name of witness: [ ]</p>	
<p>95. Name of witness: [ ]</p>	
<p>96. Name of witness: [ ]</p>	
<p>97. Name of witness: [ ]</p>	
<p>98. Name of witness: [ ]</p>	
<p>99. Name of witness: [ ]</p>	
<p>100. Name of witness: [ ]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12800 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 22c,d FilmG236 12-2-58 et  
CERTIFICATE OF DEATH

12865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5601-31st Ave.</u>				d. STREET ADDRESS <u>5601-31st Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Portch</u> Last				4. DATE OF DEATH <u>Nov. 21</u> Month <u>Nov.</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Albemarle Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>7104-Varnum H. Anderson Hill</u>			
17. INFORMANT <u>Helen M. Frith</u> Address <u>7409 Varnum St. Hyattsville, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>cerebral thromboses</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u>				DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1949</u> , 19 <u>49</u> , to <u>11/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>58</u> , and that death occurred at <u>3:36 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. E. Mosser</u> M.D.				ADDRESS (Street, city or town, state) <u>7409 VARNUM ST. Hyattsville, Md.</u>			
DATE SIGNED <u>11/11/58</u>							
PHYSICIAN'S NAME (Type) <u>F. E. Mosser</u>				ADDRESS <u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				24. REC'D BY REGISTRAR <u>NOV 26 '58</u>			
25. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12843

### CERTIFICATE OF DEATH

12866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREEN BURNIE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>RENNIE</b> Last <b>RENNIE</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-2-1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>				13. FATHER'S NAME <b>WILLIAM TERFER</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>HOSPITAL RECORDS LAUREL SANITARIUM</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>several years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis with psychotic reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. ft.</b> Month <b>19</b> Day <b>19</b> Year <b>1958</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> to <b>Nov. 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov. 24</b> , 19 <b>58</b> , and that death occurred at <b>8:15</b> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Erika P. Kraemer</b>				ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b>			
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>				DATE SIGNED <b>11-24-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/28/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>		22d. LOCATION (City, town, or county) (State) <b>A.A. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirby</b>				24a. REC'D BY REGISTRAR <b>NOV 25 1958</b>			
ADDRESS <b>Green Burnie, Md</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. Howe</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated representative, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12844 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Comedy Hills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>511-Comedy Hills Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Grace</u>		4. DATE OF DEATH <u>Nov 22 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>Camello Ficco</u>		14. MOTHER'S MAIDEN NAME <u>Louise Mongina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Vincent Ficco</u>	
16. SOCIAL SECURITY NO. <u>442X</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		24a. REC'D BY REGISTRAR <u>Nov 26 '58</u>	
ADDRESS <u>517 11th St. S.E., Wash., D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

STATE OF  
DEATH CERTIFICATE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12868

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 West Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>2100 Charleston Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Philipina Robinson</b>			4. DATE OF DEATH Month Day Year <b>November 5, 19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-6-66</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Jacob Weber</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Nicholas</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hazel Sperry; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>904.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Shock</b> (a), stating the underlying cause lost, (c) <b>Fracture of right femur</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in nursing home. 7417 Carroll Ave, Takoma Park, Md.</b>			
20c. TIME OF INJURY Hour <b>4.00</b> p. m. Month, Day, Year <b>10-13- 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home</b>	20f. (City or town) <b>Takoma Park, Montgomery, Md.</b>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>11/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>COLUMBUS, OHIO</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b>		ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
COUNTY OF [ ]

1. Name of Deceased: [ ]  
2. Sex: [ ]  
3. Age: [ ]  
4. Date of Birth: [ ]  
5. Place of Birth: [ ]  
6. Usual Residence: [ ]  
7. Cause of Death: [ ]  
8. Manner of Death: [ ]  
9. Signature of Examiner: [ ]  
10. Date: [ ]

11. Signature of Physician: [ ]  
12. Date: [ ]  
13. Signature of Coroner: [ ]  
14. Date: [ ]  
15. Signature of Medical Examiner: [ ]  
16. Date: [ ]

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12846**  
**CERTIFICATE OF DEATH**

12869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2711 Crest Ave</u>				d. STREET ADDRESS <u>2711 Crest Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Andrew</u> Last <u>Rogers</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1958</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> Hours <u>19</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cloths</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William K Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Mary M Nicol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT <u>Josephine C Rogers</u> Address <u>Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteriosclerotic Heart Disease</u> DUE TO (c) <u>9 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1953, to <u>Nov 4</u> , 1958, that I last saw the deceased alive on <u>Nov 3</u> , 1958, and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Borneau</u>		ADDRESS (Street, city or town, state) <u>3503 Pennys ST</u>		DATE SIGNED <u>11/4/58</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BORNEAU</u>		M.D. <u>MT RAINIER MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12870

12847

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>40 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>4512 B urlington Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>J.</b> Last <b>Ross</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>2</b> Year <b>19 58</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 27, 1874</b>			
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. <b>84</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. <b>84</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plate Printer U S Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chicago, Illinois</b>				11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Myrtle Dodson</b>				17. INFORMANT <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Anterior descending Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>11-1</b> , 19 <b>54</b> , to <b>11-1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 1</b> , 19 <b>58</b> , and that death occurred at <b>6:35A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dr. Aaron Deitz</b> M.D. <b>Hyattsville Md.</b> ADDRESS (Street, city or town, state) <b>Hyattsville Md.</b> DATE SIGNED <b>11-1-58</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 5, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 5 58</b>		24b. REGISTRAR'S SIGNATURE <b>James S. Thomas</b>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of justice of the peace		18. Signature of police officer		19. Signature of fireman		20. Signature of other official	
21. Signature of other official		22. Signature of other official		23. Signature of other official		24. Signature of other official		25. Signature of other official	
26. Signature of other official		27. Signature of other official		28. Signature of other official		29. Signature of other official		30. Signature of other official	
31. Signature of other official		32. Signature of other official		33. Signature of other official		34. Signature of other official		35. Signature of other official	
36. Signature of other official		37. Signature of other official		38. Signature of other official		39. Signature of other official		40. Signature of other official	
41. Signature of other official		42. Signature of other official		43. Signature of other official		44. Signature of other official		45. Signature of other official	
46. Signature of other official		47. Signature of other official		48. Signature of other official		49. Signature of other official		50. Signature of other official	
51. Signature of other official		52. Signature of other official		53. Signature of other official		54. Signature of other official		55. Signature of other official	
56. Signature of other official		57. Signature of other official		58. Signature of other official		59. Signature of other official		60. Signature of other official	
61. Signature of other official		62. Signature of other official		63. Signature of other official		64. Signature of other official		65. Signature of other official	
66. Signature of other official		67. Signature of other official		68. Signature of other official		69. Signature of other official		70. Signature of other official	
71. Signature of other official		72. Signature of other official		73. Signature of other official		74. Signature of other official		75. Signature of other official	
76. Signature of other official		77. Signature of other official		78. Signature of other official		79. Signature of other official		80. Signature of other official	
81. Signature of other official		82. Signature of other official		83. Signature of other official		84. Signature of other official		85. Signature of other official	
86. Signature of other official		87. Signature of other official		88. Signature of other official		89. Signature of other official		90. Signature of other official	
91. Signature of other official		92. Signature of other official		93. Signature of other official		94. Signature of other official		95. Signature of other official	
96. Signature of other official		97. Signature of other official		98. Signature of other official		99. Signature of other official		100. Signature of other official	



12848

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>20 Hr 5Min</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Sapp</b>				4. DATE OF DEATH <b>Nov. 17 19 58</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Nov. 16 1958</b>			
9. AGE (In years last birthday) <b>20</b>				10. IF UNDER 1 YEAR <b>20</b> IF UNDER 24 HRS <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Marion Emory Sapp</b>			
14. MOTHER'S MAIDEN NAME <b>Maxine Loraine Berry</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mother</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>776x</b> IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO (b) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Nov. 16 1958</b> to <b>Nov. 17 1958</b> , that I last saw the deceased alive on <b>Nov. 17 1958</b> , and that death occurred at <b>11:30AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harry E. Altman</b>				ADDRESS (Street, city or town, state) <b>1475 Euclid St. N.W.</b>			
PHYSICIAN'S NAME (Type) <b>Harry E. Altman</b>				DATE SIGNED <b>Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				22b. DATE THEREOF <b>12/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>	
22d. LOCATION (City, town, or county) <b>Cheverly, Md.</b>				22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>				24a. REC'D BY REGISTRAR <b>DEC 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12871

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Staffs ville</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Johnstown</b>		<b>75x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1500 Kanawha St Apt 203</b>				d. STREET ADDRESS <b>352 Arthur Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maude</b> First <b>Elsie Shaffer</b> Middle <b>Nov</b> Last 4. DATE OF DEATH Month <b>21</b> Day <b>1958</b> Year							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 8, 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b>13</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>FRED HILL</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN TRUAX</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>SUSAN SHAFER</b> Address <b>1500 KANAWHA ST. APT 203</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Generalized Atherosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 11</b> , 19 <b>58</b> , to <b>Nov 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 11</b> , 19 <b>58</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1021 University Blvd E</b> DATE SIGNED ACTUAL SIGNATURE <b>Richard L. Whelton</b> M.D. <b>Richard L. Whelton</b> M.D. <b>Silver Spring Maryland</b>							
22a. REMOVAL OF REMAINS (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grand view Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Johnstown, Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Humphrey</b> Inc. ADDRESS <b>Silver Spring</b>				24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw</b>	



12886

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park, Md</b>				c. LENGTH OF STAY IN 1b <b>24 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park, Md.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4301 Clagett Road</b>			
d. STREET ADDRESS <b>4301 Clagett Road,.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>L.</b> Last <b>Simmers</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> , Year <b>1958-</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jacob C Simmers</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Layman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Oma R Sellers</b> Address <b>University Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prostatic Obstruction (Prost.)</b> DUE TO (c) <b>Prostatic Hypertrophy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 month</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X Bronchial Pneumonia 7 Senility Oct 8 to Oct 15-1958</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Harrisonburg Va.</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>10-8</b> , 19 <b>58</b> , to <b>11-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-13</b> , 19 <b>58</b> , and that death occurred at <b>1:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Perry St</b> DATE SIGNED <b>11-14-58</b>							
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>		M.D. <b>3503 Perry St</b>		DATE SIGNED <b>11-14-58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Waldo B. Moyers</b>		<b>Mt. Rainier</b>		<b>Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harrisonburg, Va</b>		22d. LOCATION (City, town, or county) (State) <b>Harrisonburg Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12849

## CERTIFICATE OF DEATH

12873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>42 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>1 5352 Quincy Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jesse</b>		First		Middle <b>Simpson</b>		Last	
4. DATE OF DEATH <b>Nov</b>		Month		Day <b>30</b>		Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1881</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN. DRUG BUSINESS</b>		11. BIRTHPLACE (State or foreign country) <b>PRINCE GEORGES Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM SIMPSON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH MOORE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-466444</b>		17. INFORMANT <b>Mrs DOROTHY E. GALL, 642-A ST. N. E. WASH. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gangrene right leg</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Embolus right Femoral Artery</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>6 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/19</b> , 19 <b>58</b> to <b>11/30</b> , 19 <b>58</b> that I last saw the deceased alive on <b>11/30</b> , 19 <b>58</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman Donat Bureau</b>		M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St</b>		DATE SIGNED <b>11/30/58</b>	
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT BUREAU</b>				<b>MT RAINIER MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>DEC 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASH'N NATIONAL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND PEECOG Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thoma</b>		ADDRESS <b>254 CARRILL ST NW D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12802

CERTIFICATE OF DEATH

12874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. LENGTH OF STAY IN 1b 9 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md			
				d. STREET ADDRESS 1 9104 48th place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Middle Frank Last Smith				4. DATE OF DEATH Month Nov Day 20, Year 1958 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 12, 1876	
				9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Henry C Smith				14. MOTHER'S MAIDEN NAME Matilda Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 715 18 6471		17. INFORMANT Virginia Moles College Park, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from 8-8-58, 19, to 11-20, 1958, that I last saw the deceased alive on 11-19, 1958, and that death occurred at 10:4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. Deitz</i>				ADDRESS (Street, city or town, state) 4314- GALLATIN ST.			
PHYSICIAN'S NAME (Type) AARON DEITZ, M.D.				DATE SIGNED HYATTSTVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE



12887

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23 DC</u>		c. LENGTH OF STAY IN TB <u>22 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4644 Davis Ave SE Washington 23 DC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Harrison Strahan Jr</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>8th</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1890 68</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas H. Strahan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Milton Strahan</u>		18. ADDRESS <u>4644 Davis Ave SE Washington 23 DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> (c) <u>Acute Cystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>unknown</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Natta</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5440 Silver Hill Rd SE Washington 28 DC</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>		ADDRESS <u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town or county) (State) <u>Stundand Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co Inc</u>		ADDRESS <u>517 11th St SE</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12888

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dead on arrival x Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. Dobsons Office		d. STREET ADDRESS 19 McKay Road	
3. NAME OF DECEASED (Type or print) Donald King Strong		4. DATE OF DEATH November 28 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1958
		9. AGE (In years last birthday) yrs. 28	IF UNDER 1 YEAR 8 17 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland D. C.	
11. BIRTHPLACE (State or foreign country) Maryland D. C.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Charles Lewis Strong		14. MOTHER'S MAIDEN NAME Christine Kidd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles Lewis Strong, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 924.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to smothering in bed clothing DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Caught between the mattress and side of bed	
20c. TIME OF INJURY Month, Day, Year 12:30 XX 11/28 58	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Brandywine (County) P. G. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY XXXXX		22d. LOCATION (City, town, or county) Arlington Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '56	
		24b. REGISTRAR'S SIGNATURE Charles S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12850

CERTIFICATE OF DEATH

12877

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4--B--Ridge Road</b>				d. STREET ADDRESS <b>4--B--Ridge Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE ELIJAH SULLIVAN</b>				4. DATE OF DEATH Month Day Year <b>November 26th, 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 19th, 1906</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval Gun Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Falls Church, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Edgar Elijah Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Ann Beach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>577-01-4194</b>		17. INFORMANT <b>Mrs. Rosella Sullivan, 4-B Ridge Rd. Greenbelt, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>14 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I attended the deceased from <b>September 27, 1957</b> , to <b>November 26, 1958</b> , that I last saw the deceased alive on <b>November 25, 1958</b> , and that death occurred at <b>6:20A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>30-C Ridge Road, Greenbelt, Md.</b> DATE SIGNED <b>11/26/58</b>							
ACTUAL SIGNATURE <b>Hans Wodak</b>				M.D. <b>30-C Ridge Road, Greenbelt, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Hans Wodak</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29th, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		22d. LOCATION (City, county, state) <b>Prince Georges Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 1 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12803

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>PR. GEO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 RIVERSDALE MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>C.</b> Last <b>TANIS</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-21-'77</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Post Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Reporter</b>		11. BIRTHPLACE (State or foreign country) <b>ISLE OF TEXILE, HOLLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard Tanis</b>				14. MOTHER'S MAIDEN NAME <b>Anna Mantie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>2.</b> Address <b>105 EPM TANIS - 6614 - 74th, HYATTSVILLE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO <b>1 YEAR</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JAN 1</b> , 19 <b>58</b> , to <b>NOV 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>NOV 27</b> , 19 <b>58</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE MT. RAINIER MD.</b> DATE SIGNED <b>11-27-58</b>							
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.							
PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12/1/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Rainier, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. J. J.</b> ADDRESS <b>475-H 24th St.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12879

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Pr. Geo.</b></span>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>5708 Ager Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary Adell Taylor</b>			4. DATE OF DEATH <b>November 10, 1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-19</b>		9. AGE (In years last birthday) <b>39</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Aberta Province, Canada</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William D. Woodward</b>			14. MOTHER'S MAIDEN NAME <b>Amy Morehouse</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hazel Woodward; 1314 Floral St. N.W. Wash., D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary tuberculosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver, Chronic pancreatitis.</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12880

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>5th Street</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5th Street</b>			d. STREET ADDRESS <b>5th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth Taylor</b>			4. DATE OF DEATH Month Day Year <b>November 15, 19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-21</b>		9. AGE (in years last birthday) <b>37</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Louis Brown</b>			14. MOTHER'S MAIDEN NAME <b>Mary Wood</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Gus Taylor; Same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shotgun wound of head</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gun shot wound of head, caused by another person.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>8:40 P.M.</b> <b>11-15-19 58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
		20f. (City or town) <b>Bowie</b>		(County) <b>Pr. Geo.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John J. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>11-16-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-22-58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Church of Ascension</b>	
				22d. LOCATION (City, town, or county) (State) <b>Bowie Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b>		ADDRESS <b>467 N. St NW</b>		24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12881

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>2-0-2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>1032 Brady Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anne Rosalie Thompson</u>				4. DATE OF DEATH Month Day Year <u>11-9-1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-01</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Same address</u>	
13. FATHER'S NAME <u>John E. Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Frances Macabe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Albert Thompson</u> Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>stating the underlying cause lost.</u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN J. MALONEY MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-9-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kraus</u>	

ALL, TWO STATE DEPARTMENT OF HEALTH-BALTIMORE, IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12853

12882

1. PLACE OF DEATH a. COUNTY <u>4812 Riverside Rd</u> <u>Riverside</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverside</u>	c. LENGTH OF STAY IN 1b <u>25</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4812 Riverside Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>F</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Hamburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Fryer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schwartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>N6</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dr. E. K. Thompson - 1125 N. Calvert St.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>11/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>58</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore 3, Md.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>W. H. Townshend</u> M.D. <u>14 E. Egan St</u>			
PHYSICIAN'S NAME (Type) <u>W. H. TOWNSHEND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>11/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekens &amp; Sons - Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Walter E. Turner</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

12804

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Hyattsville</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6611 Stockton Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James T Townsend</b>				4. DATE OF DEATH <b>November 18, 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1871</b>	
9. AGE (In years last birthday) <b>87</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>James Towensend</b>				14. MOTHER'S MAIDEN NAME <b>Liza Jane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Lewis H. Boss</b>				Address <b>6611 Stockton Lane Hyatts.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> <b>480.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio</b> DUE TO (c) <b>Vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 55</b> to <b>Nov. 18</b> 19 <b>58</b> that I last saw the deceased alive on <b>Nov. 18</b> 19 <b>58</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert R. Hottel</b>				ADDRESS (Street, city or town, state) <b>1222 Monrow St. N.E. Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Robert R. Hottel</b>				DATE SIGNED <b>Nov. 18, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>				ADDRESS <b>4812 Ga. Ave. N.W.D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

CERTIFICATE OF DEATH

1930

Page No.

Heart

Stroke

Brain

601 Stockton Lane

601 Stockton Lane

November 18, 1930

Townsend

James

April 1, 1871

White

White

U.S.A.

Maryland

Maryland

Miss Jane

James Townsend

James H. Post 601 Stockton Lane

Arteriosclerosis Cordis

Arteriosclerosis Cordis

Vascular Disease

Male

Nov. 18, 1930

Nov. 18, 1930

1930 Nov. 18, 1930

Robert E. Butler

Nov. 21 28 Rock Creek Cemetery Washington, D. C.

Deaf - removed home 4515 Ave. N.W.D.C.

12805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STULIA B TRACEY</u>				4. DATE OF DEATH Month Day Year <u>NOV. 2 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 9 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM J. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA J. REEVES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>THOMAS B. NOONE Cheverly 4, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT.</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>5 YRS.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>Hour 11/2 p.m. 11/2</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JUNE 1, 1953</u> , to <u>11/2, 1958</u> , that I last saw the deceased alive on <u>11/2, 1958</u> , and that death occurred at <u>4:02 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D. <u>400-17 ST. N.W.</u>				DATE SIGNED <u>11/4/58</u>			
PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>				ADDRESS (Street, city or town, state) <u>WASHINGTON 6, D.C.</u>			
22a. RURAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>11-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee Jones</u> ADDRESS <u>Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

12806

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTVILLE, MD.</u>		c. LENGTH OF STAY IN 1b <u>154917 - RUSSELL AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>1 HYATTSTVILLE, MD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>L.</u> Last <u>TYLOR</u>		4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WINDOW DRESSER - CLERK - LOEB CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE TYLOR</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE BUCHANAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-03-83724</u>	
17. INFORMANT <u>Sister M. Joan Theresa O. Gorm.</u>		Address <u>Carroll Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Senile arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1928</u> , to <u>Nov 5, 1958</u> , that I last saw the deceased alive on <u>Nov 1, 1958</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>4601 16th St. N.W.</u>	
DATE SIGNED <u>11/5/58</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. SPIRE</u>		4601 - 16TH. STREET, N. W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins 3821-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

# CERTIFICATE OF DEATH

1886

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Farmer		Heart Disease		Home		Jan 15, 1900		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of Birth		Date of Birth		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
New York		Jan 1, 1855		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Place of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Cause of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Heart Disease		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Place of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

## CERTIFICATE OF DEATH

12886

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park, Md</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8212 Sherrill St</b>		d. STREET ADDRESS <b>8202 Sherrill St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Harvey</b> Last <b>Watkins</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/31</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION: (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles W Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Elsie M Sherry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Audrey Watkins Palmer Park, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Brain Tumor</b> <b>1930</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>14 Mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 7, 1957</b> to <b>Nov 19, 1958</b> , that I last saw the deceased alive on <b>Nov 18, 1959</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Rosson M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>November 19, 1958</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, M.D.</b>		<b>5304 Annapolis rd., Bladenburgh, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 12807 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C. SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>		e. STREET ADDRESS <b>1608 East West Hgwy.</b>	
3. NAME OF DECEASED (Type or print) <b>Loretto L Watt</b>		4. DATE OF DEATH <b>NOV. 3 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BOARMAN</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA DEAKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Jessie M. Miller 1608 East West Hgwy.</b>		Address <b>Bel. Sp. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of The Ampulla of Vater - with metastases</b> 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1957</b> to <b>11-3</b> , 1958, that I last saw the deceased alive on <b>11-2</b> , 1958, and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4201 Mass. Ave. NW</b> DATE SIGNED <b>11-3-58</b> ACTUAL SIGNATURE <b>R. M. Tilley, Jr. M.D.</b> PHYSICIAN'S NAME (Type) <b>Wash. 16 DC.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins 3821-14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

100

REGISTER & SIGNATURE

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

1935

WILLIAM B. OAKMAN

NAME OF DECEASED		DATE OF DEATH	
WILLIAM B. OAKMAN		JANUARY 1, 1935	
AGE		SEX	
65		Male	
RACE		EDUCATION	
White		High School	
BIRTH DATE		PLACE OF BIRTH	
JANUARY 1, 1870		NEW YORK	
OCCUPATION		CAUSE OF DEATH	
Teacher		Heart Disease	
MARITAL STATUS		MANNER OF DEATH	
Married		Natural	
SPOUSE NAME		SIGNATURE OF DECEASED	
Mary B. Oakman		[Signature]	
SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
[Signatures]		[Signature]	
LOCAL HEALTH OFFICER		STATE HEALTH OFFICER	
[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

V3. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12855

12889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>009</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u>		d. STREET ADDRESS <u>6333 Brooks Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u> First <u>Brindell</u> Middle <u>White</u> Last		4. DATE OF DEATH <u>NOVEMBER</u> Month <u>8</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-27</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Roland White</u>		14. MOTHER'S MAIDEN NAME <u>Nora Pinkney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-40-1703</u>	
17. INFORMANT <u></u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ruptured left lung</u> (a), stating the underlying cause last. (c) <u>Crushed chest.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of a parked car struck by another automobile</u>	
20c. TIME OF INJURY Month. Day. Year <u>4-11-58</u> Hour <u>11-7</u> a. m. <u>PM</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Landover-Rd-Geo-Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-8-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-12-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bridgely Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Central Ave Landover Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		24. REC'D BY REGISTRAR <u>NOV 13 '58</u>	
ADDRESS <u>467 Nat Me</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

13355

STATE DEPARTMENT OF HEALTH - BAL MORE 75  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10-15-1975	
Place of Birth		Date of Birth		Cause of Death		Manner of Death		Occupation	
New York, N.Y.		10-15-1930		Heart Disease		Natural		Teacher	
Residence		Date of Admission		Date of Discharge		Date of Death		Date of Burial	
123 Main St.		10-15-1975		10-15-1975		10-15-1975		10-15-1975	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Certificate		Date of Burial		Date of Interment		Date of Cremation	
10-15-1975		10-15-1975		10-15-1975		10-15-1975		10-15-1975	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 12891 CERTIFICATE OF DEATH 12890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S COUNTY</u> <u>DISTRICT OF COLUMBIA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE</u> D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4432 E ST SE</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4432 E ST SE HOSPITAL</u>		d. STREET ADDRESS <u>WASHINGTON D.C.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONDRAS</u> <u>WHITELOW</u>		4. DATE OF DEATH Month Day Year <u>NOV</u> <u>29</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGROID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 SEPT 58</u>
9. AGE (In years last birthday) yrs. <u>2</u> <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USAF HOSP-ANDREWS</u>	
11. BIRTHPLACE (State or foreign country) <u>ANDREWS AFB, WASH 25, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>ALONZO WHITELOW</u>		14. MOTHER'S MAIDEN NAME <u>GLORIA HELEN CABITT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ALONZO WHITELOW-FATHER</u>	
17. INFORMANT <u>ALONZO WHITELOW-FATHER</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastroenteritis</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 or 3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 Nov., 1958</u> , to <u>D. O. A.</u> , 19____, that I last saw the deceased alive on <u>29 Nov., 1958</u> , and that death occurred at <u>1130 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAF Hospital Andrews</u> <u>29 Nov 58</u>			
ACTUAL SIGNATURE <u>Arthur J. Deikman</u>		M.D. <u>USAF Hospital Andrews</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR J. DEIKMAN</u>		<u>Andrews AF Base, Washington 25, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/4/58</u>	22b. DATE THEREOF <u>12/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>	
ADDRESS <u>4804 Ga Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
SIGNED		SIGNED		SIGNED		SIGNED		SIGNED		SIGNED		SIGNED		SIGNED	
WITNESSED		WITNESSED		WITNESSED		WITNESSED		WITNESSED		WITNESSED		WITNESSED		WITNESSED	
FILED		FILED		FILED		FILED		FILED		FILED		FILED		FILED	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891

12892

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara Adelaide Willett</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William A. Murry</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Ruth Willett</u>		Address <u>White Plains, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>57</u> , to <u>Nov 2, 1958</u> , that I last saw the deceased alive on <u>Nov 1, 1958</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4223 Silver Hill Rd. Silver Hill, Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>John P. Deangelo</u> M.D. PHYSICIAN'S NAME (Type) <u>John P. Deangelo M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 5 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
ADDRESS <u>Waldorf, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Farmer"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Dec 15, 1950"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	

12893

CERTIFICATE OF DEATH

Reg. Dist. No.

12892

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPALDING HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SPALDING HEIGHTS</u>			
c. LENGTH OF STAY IN 1b <u>8 years</u>				d. STREET ADDRESS <u>1604--60th. AVE., S.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1604--60th. Street, S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE THOMAS WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 23, 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 14, 1879</u>	
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLASS BLOWER &amp; RET. - WINDOW GLASS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PITTSBURG, PA.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>EMILY WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-24-0573</u>		17. INFORMANT <u>MARY BLANCHE WILLIAMS - WIFE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung &amp; Metas. Breast</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1958</u> to <u>June 28, 1958</u> , that I last saw the deceased alive on <u>June 28, 1958</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T F O Donovan</u> M.D.				DATE SIGNED <u>11/23/58</u>			
PHYSICIAN'S NAME (Type) <u>T F O DONOVAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stamper, Inc. 317 Pa. Ave. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



12856 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12893

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Seat Pleasant,</b> d. STREET ADDRESS <b>6217 Foote St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph R Wood</b>		4. DATE OF DEATH Month Day Year <b>11-7 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph F Lloyd</b>		14. MOTHER'S M maiden NAME <b>Mary ann Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mother</b>		Address <b>6217 Foote St, Seat Pleasant Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung abscess, L.L.L.</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>? aspiration</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 wk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>11-3 1958</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-3</b> , 19 <b>58</b> , to <b>11-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-3</b> , 19 <b>58</b> , and that death occurred at <b>640 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Max M Herzberg</b>		ADDRESS (Street, city or town, state) <b>7016-grey St., Seat Pleasant Md 4/1/59</b>	
PHYSICIAN'S NAME (Type) <b>Max M Herzberg M.D.</b>		DATE SIGNED <b>Nov 12 '58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2077202XV4

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE

DECEASED

RESIDENT

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF INTERMENT

DATE OF INTERMENT

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF CREMATION

DATE OF CREMATION

PLACE OF EXHUMATION

DATE OF EXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12857

## CERTIFICATE OF DEATH

Reg. Dist. No.

12894

1. PLACE OF DEATH a. COUNTY <u>Prince George Gen. Hosp. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>25 Riverdale, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp.</u>				d. STREET ADDRESS <u>14306 Queensbury Road</u>			
3. NAME OF DECEASED (Type or print) First <u>HAZELE</u> Middle <u>MILLIRONS</u> Last <u>YOUNG</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min. <u>58</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Macon, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. T. Millirons</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles D. Wimpee Sr.</u>		Address <u>4306 Queensbury Rd Riverdale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov. 5, 1958</u> to <u>Nov. 10, 1958</u> , that I last saw the deceased alive on <u>November 10, 1958</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/11/58</u>							
ACTUAL SIGNATURE <u>George S. Malouf</u> M.D.				PHYSICIAN'S NAME (Type) <u>GEORGE S. MALOUF M.D. 5802 Balto Ave Hyatts Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. Riverdale Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

12557

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as stated above.		I, the undersigned, being a duly qualified registrar, do hereby certify that the above is a true and correct statement of the facts as stated above.		I, the undersigned, being a duly qualified witness, do hereby certify that the above is a true and correct statement of the facts as stated above.		I, the undersigned, being the deceased, do hereby certify that the above is a true and correct statement of the facts as stated above.	
DATE [Faint text]		TIME [Faint text]		PLACE [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		CITY [Faint text]		ZIP CODE [Faint text]		COUNTY [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>				d. STREET ADDRESS <u>13128-63rd Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Leonard M. Young</u>				4. DATE OF DEATH <u>Nov. 15</u> 19 <u>58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Col. Air Force</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Falls City, Neb.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James Edward Young</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Della Vaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Active</u>				16. SOCIAL SECURITY NO. <u>Active</u>			
17. INFORMANT <u>Bertha W. Young</u>				Address <u>address above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-15-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>				ADDRESS <u>mt Rainier</u>		24a. REC'D BY REGISTRAR <u>NOV 20 58</u>	
24b. REGISTRAR'S SIGNATURE <u>James S. Thayer</u>							

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. OCCUPATION                  _____</p>		<p>5. PLACE OF BIRTH                  _____</p>		<p>6. DATE OF BIRTH                  _____</p>	
<p>7. MARITAL STATUS                  _____</p>		<p>8. COLOR                  _____</p>		<p>9. RELIGION                  _____</p>	
<p>10. PLACE OF DEATH                  _____</p>		<p>11. DATE OF DEATH                  _____</p>		<p>12. TIME OF DEATH                  _____</p>	
<p>13. CAUSE OF DEATH                  _____</p>		<p>14. MANNER OF DEATH                  _____</p>		<p>15. SIGNATURE OF EXAMINER                  _____</p>	
<p>16. SIGNATURE OF WITNESS                  _____</p>		<p>17. SIGNATURE OF JURY                  _____</p>		<p>18. SIGNATURE OF CORONER                  _____</p>	
<p>19. SIGNATURE OF DECEASED                  _____</p>		<p>20. SIGNATURE OF NEXT OF KIN                  _____</p>		<p>21. SIGNATURE OF MINISTER                  _____</p>	
<p>22. SIGNATURE OF CHURCH                  _____</p>		<p>23. SIGNATURE OF FUNERAL HOME                  _____</p>		<p>24. SIGNATURE OF BURIAL PLACE                  _____</p>	
<p>25. SIGNATURE OF INTERVIEWER                  _____</p>		<p>26. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>27. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>28. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>29. SIGNATURE OF INTERVIEWER                  _____</p>		<p>30. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>31. SIGNATURE OF INTERVIEWER                  _____</p>		<p>32. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>33. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>34. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>35. SIGNATURE OF INTERVIEWER                  _____</p>		<p>36. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>37. SIGNATURE OF INTERVIEWER                  _____</p>		<p>38. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>39. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>40. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>41. SIGNATURE OF INTERVIEWER                  _____</p>		<p>42. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>43. SIGNATURE OF INTERVIEWER                  _____</p>		<p>44. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>45. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>46. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>47. SIGNATURE OF INTERVIEWER                  _____</p>		<p>48. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>49. SIGNATURE OF INTERVIEWER                  _____</p>		<p>50. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>51. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>52. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>53. SIGNATURE OF INTERVIEWER                  _____</p>		<p>54. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>55. SIGNATURE OF INTERVIEWER                  _____</p>		<p>56. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>57. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>58. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>59. SIGNATURE OF INTERVIEWER                  _____</p>		<p>60. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>61. SIGNATURE OF INTERVIEWER                  _____</p>		<p>62. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>63. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>64. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>65. SIGNATURE OF INTERVIEWER                  _____</p>		<p>66. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>67. SIGNATURE OF INTERVIEWER                  _____</p>		<p>68. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>69. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>70. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>71. SIGNATURE OF INTERVIEWER                  _____</p>		<p>72. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>73. SIGNATURE OF INTERVIEWER                  _____</p>		<p>74. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>75. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>76. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>77. SIGNATURE OF INTERVIEWER                  _____</p>		<p>78. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>79. SIGNATURE OF INTERVIEWER                  _____</p>		<p>80. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>81. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>82. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>83. SIGNATURE OF INTERVIEWER                  _____</p>		<p>84. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>85. SIGNATURE OF INTERVIEWER                  _____</p>		<p>86. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>87. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>88. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>89. SIGNATURE OF INTERVIEWER                  _____</p>		<p>90. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>91. SIGNATURE OF INTERVIEWER                  _____</p>		<p>92. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>93. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>94. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>95. SIGNATURE OF INTERVIEWER                  _____</p>		<p>96. SIGNATURE OF INTERVIEWEE                  _____</p>	
<p>97. SIGNATURE OF INTERVIEWER                  _____</p>		<p>98. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>99. SIGNATURE OF INTERVIEWER                  _____</p>	
<p>100. SIGNATURE OF INTERVIEWEE                  _____</p>		<p>101. SIGNATURE OF INTERVIEWER                  _____</p>		<p>102. SIGNATURE OF INTERVIEWEE                  _____</p>	